NEW YORK STATE OF OPPORTUNITY. Department of Civil Service

EMPLOYEE BENEFITS DIVISION
NYSHIP Authorization for Release of Protected Health Information

EBD-543 (2/2023)

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

NOTE: Please read the instructions on page 3 before completing this form. The only persons who can complete and sign this form to authorize the disclosure of personal information are:

- **The individual who is the subject of the information to be disclosed;**
- **A parent or legal guardian (who is currently enrolled on the same NYSHIP plan as the individual) - only if the individual who is the subject of the information to be disclosed is a child under the age of 18; or**
- **A personal representative of the individual as designated through a Power of Attorney, Health Care Proxy, a court order, or other appropriate legal documentation.**

Part A – Identify the Person Whose Information is to be Released

Name: _____ Empire Plan ID Number or last four digits of SSN: _____

Part B – Person(s) or Organization(s) Authorized to Receive Information

Please complete this section with the person(s) or organization(s) you are authorizing to receive information about the person named in Part A.

Name: _____

Street Address: _____

City, State, Zip: _____

Telephone: _____ Email: _____

Name: _____

Street Address: _____

City, State, Zip: _____

Telephone: _____ Email: _____

Possibility of Redisclosure: It is possible that the person or organization you have named to receive this information may redisclose the information and, if so, the information may no longer be protected by the federal privacy rules of the Health Insurance Portability and Accountability Act of 1996.

Part C – Information to be Released

The New York State Department of Civil Service, Employee Benefits Division (EBD) maintains information regarding eligibility for and enrollment in the New York State Health Insurance Program. This information includes, but is not necessarily limited to, names and identification numbers of all covered persons; health plan option (i.e. Empire Plan or the specific HMO in which you are enrolled); date of birth; address; premium and payment information; and employment information for purposes of determining eligibility. We do not maintain claims information or medical records. This form only allows for the release of information and does not allow the person named in Part B to make any changes to the enrollee's NYSHIP account unless they have independent authority to do so.

☐ I authorize the release of information maintained by EBD as described above.

☐ I authorize the release of information maintained by EBD as described above with the following limitations: *(Please describe)*

_____

_____

_____

Part D – Purpose of Disclosure

You must check one of the following boxes to indicate a purpose for this release of information:

☐ Per my request

☐ Other: _____

Part E – Expiration of Authorization

This authorization will remain in effect until I am no longer enrolled in the NYSHIP unless another date or event is specified below.

☐ On the following date: _____

☐ When the following event occurs: _____

Terms for Termination/Revocation: You have the right to revoke this authorization at any time. However, your revocation will not affect any use or disclosure that we made in reliance upon your authorization before we learn of your revocation. You may revoke this authorization by writing to the NYSHIP Privacy Official at the address provided below.

Part F – Required Signature

I authorize release of the above-specified information. I understand that I am not required to sign this form in order to receive or to be eligible to receive health care benefits (enrollment, treatment, or payment).

_____ _____
Signature **Date**

_____ _____
Empire Plan ID Number or last four digits of SSN **Telephone Number**

If the person signing this form is not the individual whose information is being disclosed, please indicate your relationship to that person:

☐ Parent or legal guardian of a child under the age of 18 (applicable only when the parent or legal guardian is currently enrolled on the same NYSHIP plan as the child).

☐ Personal representative **(please attach documentation, i.e., Power of Attorney, Court Order, Health Care Proxy).**

Mail this form to the following address:

NYS Department of Civil Service
Employee Benefits Division
Albany, NY 12239

PLEASE KEEP A COPY OF THIS FORM FOR YOUR RECORDS

Personal Privacy Protection Law Notification: The information you provide on this form is requested for the principal purpose of authorizing the use and/or disclosure of protected health information pursuant to 45 CFR 164.508. Failure to provide the information may interfere with our ability to use or disclose protected health information necessary to administer NYSHIP. This information will be used in accordance with Section 96 (1)(a) of the Personal Privacy Protection Law. This information will be maintained by the Director, Employee Benefits Division, Department of Civil Service, Albany, NY 12239; (518) 473-1977. For information relating only to the Personal Privacy Protection Law, call (518) 457-9375.

Instructions for completion of the *NYSHIP Authorization for Release of Protected Health Information Form* (EBD-543)

The attached EBD-543 form must be completed in its entirety. If you have any questions while completing the form, please contact EBD at 1-800-833-4344.

Part A - This space requires providing the name and identification number of the New York State Health Insurance Program (NYSHIP) enrollee/subscriber (or dependent over the age of 18) if you wish to designate someone to be given information about you, put in **your** name and **your** Social Security Number (SSN), or Survivor number, or COBRA number **or** your Alternate Identification number. The Alternate Identification number can be found on your Empire Plan health insurance card (If you are a dependent over the age of 18, you must note the identification number that you are covered under as well as your own SSN.) However, if you are enrolled in an HMO, please do not use your HMO identification number.

Part B - This section must be completed with the name(s) of person(s) or organizations you wish to authorize the Employee Benefits Division's release of information to concerning your health insurance enrollment record.

Part C - Information to be Released: You must check one of the two options. If you check the second option, you must describe any limitations you wish to place on information that you are permitting to be disclosed.

Part D - Purpose for Release of Information: You must place a check in at least one of the boxes. If you choose "Other", you must write in the purpose for the release of information. Checking "Per My Request" will require submission by you of a request for each individual to whom you wish the Employee Benefits Division to release information.

Part E - If you do not complete this section, the authorization will remain in effect until you are no longer enrolled in NYSHIP. If you place a check mark in front of "when the following event occurs:" you must designate an event; for example, "one year from the date the Authorization is signed."

Part F - You must sign and date the document; provide your identification number and your telephone number. If you are the parent or legal guardian of a child under the age of 18 (who is currently enrolled on the same NYSHIP plan as the child) check the "Parent or legal guardian of a child under the age of 18" box. If you are completing and signing this form as a representative for the enrollee (including a parent of a disabled child over the age of 18), you **must** provide documentation enabling you to act on that person's behalf. Such documentation might include, but not be limited to, a Power of Attorney or Court Order. Absence of required documentation will render this Authorization for Release of Protected Health Information ineffectual.