NEW YORK STATE OF OPPORTUNITY. Department of Civil Service

NYSHIP Authorization for Release of Protected Health Information – "Health Maintenance Organizations Specifications for the New York State Health Insurance Program"

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

NOTE: 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 - 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: _____ Identification #: _____

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: _____ E-mail: _____

Name: _____

Street Address: _____

City, State, Zip: _____

Telephone: _____ E-mail: _____

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.

☐ 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)

_____

_____

_____

_____

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NYSHIP Authorization for Release of Protected Health Information - RFP entitled: "Health Maintenance Organizations Specifications for the New York State Health Insurance Program"

Part D – Purpose of Disclosure

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

- ☐ Per my request
- ☐ To permit a family member or friend to act on my behalf
- ☐ Other _____

Part E – Expiration of Authorization

This authorization will remain in effect for twelve (12) months from the date of your signature unless another date or event that will cause the authorization to expire is specified below:

- ☐ When I am no longer enrolled in the New York State Health Insurance Program (NYSHIP)
- ☐ On (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**

_____ _____

Identification # **Telephone #**

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
- ☐ 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.