



State of New York
Department of Civil Service
Alfred E. Smith Office Bldg.
Albany, NY 12239

EMPLOYEE BENEFITS DIVISION
Instruction form for EBD-543
Authorization for Release of Health Information

(w) EBD-543I (7/08)

The attached EBD-543I form must be completed in its entirety. If you have any questions while completing the form please contact us 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, 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 and begins with an 890... (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 social security number.) 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 mark in the space in front of at least one of the lines. If you check the space in front of "Other", you must write in the purpose for the release of information. Checking "Per Your Request" will require submission by you of a request for each instance you wish the Employee Benefits Division to release information.

Part E – If you do not complete this section, the authorization will only remain in effect for 1 year from the signed document. If you place a check mark in front of "when the following event occurs:" you **must** designate an event; for example, "as long as I am covered in the NYSHIP," or "as long as I live."

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, put a check mark on the space preceding, "Parent or legal guardian of a child under the age of 18." 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 Health Information ineffectual.