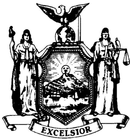


State of New York
Department of Civil Service
The State Campus
Albany, NY 12239

EMPLOYEE BENEFITS DIVISION
Authorization for Release of Health Information

EBD-543 (4/03L)

NEW YORK STATE HEALTH INSURANCE PROGRAM (NYSHIP) and NEW YORK STATE PUBLIC EMPLOYEE AND RETIREE LONG TERM CARE INSURANCE PROGRAM (NYPERL)

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Please complete all sections of this form. This authorization will not be valid until all sections are completed.

I *(please print your name)* ____ hereby request and authorize the release of the information described below.

Fill in the name of the person whose Protected Health Information you are authorizing to be disclosed:

Name:____ ID Number:___________________________________

What is your relationship to this person?

_____Self _____Parent _____Guardian _____Personal Representative (Please provide documentation, such as a Court Order, Power of Attorney, Health Care Proxy, etc.)

Please identify the person(s) or organization(s) you are authorizing to release the information:

____ **NYS Dept. of Civil Service Employee Benefits Division**

Empire Plan:

____ Empire Blue Cross and Blue Shield (Hospital Insurer)

____ United HealthCare (Medical Insurer)

____ Group Health Inc. (Mental Health and Substance Abuse Insurer)

____ CIGNA (Prescription Drug insurer)

____ **Davis Vision (Vision Plan Administrator)**

____ **Group Health Inc. (Dental Plan Insurer)**

____ **MedAmerica (Long Term Care)**

____ **NYSHIP Health Maintenance Organization - please indicate specific HMO:** ______________________________

____ **Other:** ____

Please list the name and address of the person(s) or organization(s) you want to receive the information:

Name: ____

Street Address: ____

City, State, Zip: ____

Name: ____

Street Address: ____

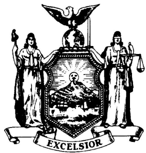
City, State, Zip: ____

Possibility of Re-disclosure: It is possible that the person or organization you have named to receive this information may re-disclose 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.

Please describe the purpose for which the information is to be released. If you do not wish to describe the purpose, please mark "At the request of the individual".

____ At the request of the individual

____ (please describe):____



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EMPLOYEE BENEFITS DIVISION

Authorization for Release of Health Information

Please indicate the information to be released (check all that apply):

____ Social Security Number (Health Insurance Identification Number)

____ Identifying Information, including date of birth, address, gender, marital status

____ Employment information as recorded on health insurance enrollment records

____ Enrollment information, including names and identification numbers of covered persons for:
___ Health ___Dental ___Vision ___Long Term Care

____ Premium information (including sick leave credit, pre-tax election, salary/pension deductions, direct payments, Medicare reimbursement) for: ___ Health ___Dental ___Vision ___Long Term Care

____ Claims information for: ___ Health ___Dental ___Vision ___Long Term Care
Please indicate specific claim(s) you would like disclosure limited to: ____________________________________

____ Other (specify): ____

____ Other (specify): ____

____ **All of the above**

Expiration of Authorization: This authorization will remain effective for twelve (12) months from the date of your signature unless you specify a different date or an event that will cause the authorization to expire.
You may specify an expiration date or event for this authorization: ____

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:

NYSHIP/NYPERL Privacy Official
NYS Department of Civil Service
Building 1, State Campus
Albany, NY 12239

Please note that if you authorized other persons or organizations, such as the NYSHIP health insurance carriers, to disclose information, your written request to revoke your authorization must be sent directly to that person or organization.

You are not required to sign this form to receive health care benefits (enrollment, treatment, or payment).

Required Signature:

I authorize release of the above specified information as indicated.

____________________________________	______________________	______________________
Signature	ID Number	Date

Please submit this form to the persons or organizations you are authorizing to release the information.

Please keep a copy of this form for your records.

Personal Privacy Protection Law Notification:

This information you provide on this application is requested for the principal purpose of enabling the Department of Civil Service to process your authorization to use or disclose protected health information. This information will be used in accordance with Section 96 (1) of the Personal Privacy Protection Law, particularly subdivisions (b), (e) and (f). This information will be maintained by the Director of the Employee Benefits Division, NYS Department of Civil Service, The State Campus, Albany, NY 12239. For information concerning the Personal Privacy Protection Law, call (518) 457-9375. If you have a question regarding this form or the health insurance coverage please call (518) 457-5754 or 1-800-833-4344 between the hours of 9:00 a.m. and 3:00 p.m.