

# Authorization to Use and/or Disclose Personal Health Plan Information

Form Received By \_\_\_\_\_

Date \_\_\_\_\_

1. Employee Name	1a. Employee Health Plan ID Number
1b. Employee Date of Birth	1c. Employee Address and Phone Number
2. Name of Person Whose Health Information is the Subject of the Authorization	2a. Relationship to Employee Employee      Spouse      Child      Other <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
3. Your Name	3a. Authority If you are not the person in Box 2, please describe your authority to act on his or her behalf: _____ _____
4. Mailing Address for Records	4a. City, State, Zip Code

I hereby authorize Joint Benefit Trust to use and/or disclose the health information described in Sections A — E below.

## Section A: Health Information to be Used and/or Disclosed.

Specify the health information to be released and/or used, including (if applicable) the time period(s) to which the information relates. Select only one (1) of the following boxes:

- All of my past, present or future health claims and/or medical records.
- All of my health information, including, but not limited to, dates of service, types of service, treatment charts, x-rays, provider notes or other information, related to the following health condition:  
 \_\_\_\_\_ (please describe).
- All of my health information relating to Claim Number \_\_\_\_\_, including, but not limited to, dates of service, types of service, treatment charts, x-rays, provider notes or other information.
- Other (please specify). \_\_\_\_\_  
 \_\_\_\_\_

## Section B: Person(s) Authorized to Use and/or Receive Information.

Specify the persons or class of persons authorized to use and/or receive the health information described in Section A:

\_\_\_\_\_

**Section C: Purposes for Which Information will be Used or Disclosed.**

Specify each purpose for which the health information described in Section A may be used or disclosed. Select all of the applicable boxes below:

- To facilitate the resolution of a claim dispute.
- As part of my application for leave under the Family and Medical Leave Act (FMLA) or state family leave laws.
- For a disability coverage determination.
- At my request.
- Other (please specify) \_\_\_\_\_

**Section D: Expiration of Authorization**

Specify when this Authorization expires. (Provide a date or triggering event related to the use or disclosure of the information.)

- On the following date: \_\_\_\_\_.
- Upon the passage of the following amount of time: \_\_\_\_\_.
- Upon my disenrollment from the Plan.
- Upon my return from FMLA leave.
- Other (please specify) \_\_\_\_\_

**Your rights:**

- You can revoke this Authorization at any time by submitting a written revocation to **Joint Benefit Trust at 4160 Dublin Blvd., Suite 400, Dublin, CA 94568-7756.**
- A revocation will not apply to information that has already been used or disclosed in reliance on the Authorization.
- Once the information is disclosed pursuant to this Authorization, it may be redisclosed by the recipient and the information will no longer be protected by HIPAA.
- The Plan may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign the Authorization.
- You will be provided with a copy of this Authorization Form, after signing, if the Plan sought the Authorization.

\_\_\_\_\_  
**Signature of Participant & Date**