New York State Nurses Association

NYSNA Benefits Fund

PO Box 12430
Albany, NY 12212-2430
(877) RN BENEFITS
FAX (518) 869-2317
www.rnbenefits.org

Authorization Form

For the disclosure of personal health information

***C**omplete this form if you'd like to authorize the NYSNA Benefits Fund to release your personal health information to someone other than yourself effective April 14, 2003. If applicable, please ask your spouse and each dependent over the age of 18 and covered by the NYSNA Benefits Fund to complete his/her own form if they'd like to authorize the Benefits Fund to release their personal health information to someone other than themselves. If you do not authorize the Benefits Fund to release your personal health information to others, the Fund will not be able to provide your personal health information to anyone, including your spouse, dependents, parents and/or children.*

You and your dependents are under no obligation to sign this form. The Benefits Fund does not condition enrollment or eligibility for benefits on signing this form. Obtain additional copies of the form by photocopying this one, printing one from the forms page of the Benefits Fund Web site at www.rnbenefits.org, or contacting the Fund office at (877) RN BENEFITS [762-3633] or PO Box 12430, Albany, NY 12212.

NYSNA Benefits Fund participant's:

Name _____

Social Security number _____

Address _____

City/state/ZIP code _____

Date of birth _____

Home phone number _____

Work phone number _____

E-mail address _____

Your: *(If different than Benefits Fund participant)*

Name _____

Social Security number _____

Address _____

City/state/ZIP code _____

Date of birth _____

Home phone number _____

Work phone number _____

E-mail address _____

Authorization

I hereby authorize the NYSNA Benefits Fund to disclose the following personal health information at the request of the individual (please check appropriate boxes):

❒ Claims information

❒ Benefits information

❒ Other (please specify) _____

_____

_____

_____

I authorize that the personal health information checked be released to (please list the person[s] you'd like to give access to your personal health information):

_____

_____

_____

I understand that if the person(s) listed above are not health care providers, health plans or health care clearinghouses subject to federal privacy standards, the health information disclosed to them pursuant to this authorization may not be protected by federal privacy standards.

3/03

Please sign the other side of this form and return it to the NYSNA Benefits Fund.

Your rights

This authorization will become effective immediately and remain in effect as long as you are a Benefits Fund participant or until you revoke it. You have the right to revoke this authorization at any time, except to the extent that action has been taken in reliance on this authorization. To revoke this authorization, obtain another copy of this form by calling the Fund office or accessing the Fund's Web site and completing the authorization revocation portion of the form below.

Signature

I, _____ (please print name), have reviewed and understand the information on this form. By signing this form, I confirm that I have signed it voluntarily and that it accurately reflects my wishes regarding the use and/or disclosure of my personal health information. I hereby release the NYSNA Benefits Fund from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

_____

Your signature **Date**

_____

Signature of legal representative (if you have a health care power of attorney, a guardian, or named another statutory authorization) **Date**

Legal representative's name _____

Legal representative's address _____

Legal representative's phone number _____

Legal representative's relationship to you or nature of authority (e.g., health care power of attorney, guardian, or other statutory authorization) _____

Revocation of authorization

I hereby revoke the authorization I gave the NYSNA Benefits Fund to disclose my personal health information to _____ _____ (please print name[s] of person[s]). I understand that disclosures made in good faith may already have occurred in reliance upon my previously issued authorization and that this revocation cannot apply retroactively to such disclosures. The NYSNA Benefits Fund, its employees and officers hereby are released from any legal responsibility or liability for disclosing the information I previously authorized.

NYSNA Benefits Fund participant's:

Name _____

Social Security number _____

Address _____

City/state/ZIP code _____

Date of birth _____

Home phone number _____

Work phone number _____

E-mail address _____

Your: *(If different than Benefits Fund participant)*

Name _____

Social Security number _____

Address _____

City/state/ZIP code _____

Date of birth _____

Home phone number _____

Work phone number _____

E-mail address _____

_____

Your signature **Date**

_____

Signature of legal representative (if you have a health care power of attorney, a guardian, or named another statutory authorization) **Date**