## STATE HEALTH BENEFITS PROGRAM

## MEMBER AUTHORIZATION FORM FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Member's Name:				
	LAST	FIRST		MI
Address:				
Daytime Telephone Numb	er: ( )	E-mail:		
Member's Social Security N	Number:		Date of Birth:	// 

By signing this form I authorize the State Health Benefits Program (SHBP) to use and/or disclose my health information (information that constitutes protected health information as defined in the Privacy Rule of the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act [HIPAA] of 1996) in the manner described below. The SHBP will not condition treatment, payment, enrollment in a health plan, or eligibility for health care benefits on my decision to sign this authorization.

I have signed this form voluntarily to document my wishes regarding the use and/or disclosure of the health information described below.

**1.** Description of Health Information I Authorize to be Used or Disclosed. The following is a specific description of the health information I authorize be used and/or disclosed:

2. Description of Each Purpose for the Requested Use and/or Disclosure. I authorize my health information to be used and/or disclosed for the following specific purposes:

**3. Persons/Organizations Authorized to Receive and/or Use My Health Information.** I authorize the following person(s) and/or organization(s) to receive my health information from the SHBP and to use or disclose such information for the purposes listed above. I understand that the health information disclosed pursuant to this authorization may no longer be protected by the federal privacy standards and may be redisclosed without obtaining my authorization.

4. Right to Revoke. I understand that I have the right to revoke this authorization at any time and that my revocation of this authorization must be in writing. I understand that any revocation must include my name, address, telephone number, the date of this authorization, and my signature and that I should send it to the State Health Benefits Program — HIPAA Privacy Officer, State of New Jersey, Department of the Treasury, Division of Pensions and Benefits, PO Box 295, Trenton, NJ 08625-0295. I am aware that my revocation will not be effective as to uses and/or disclosures of my health information that have already been made in reliance upon this authorization.

## 5. Expiration of Authorization. This authorization will expire (check one and complete):

On:		/		/	
_	MM	/	DD	/	YYYY

Upon the occurrence of the following event(s) or until I revoke this authorization:

## **MEMBER'S SIGNATURE**

I have had an opportunity to review and understand the contents of this form. By signing this form, I am confirming that it accurately reflects my wishes.

	Date: / /
MEMBER'S SIGNATURE	MM / DD / YYYY
If signed by a personal representative, complete the following:	
Name of Personal Representative:	
<b>Relationship to Member or Nature of Authority:</b> (e.g., health care power of attorney, guardian, other legal authorization — A copy	y of documentation must be attached.):
Address:	
Daytime Telephone Number: () E-mail:	
SIGNATURE OF PERSONAL REPRESENTATIVE	<b>Date:</b> //
SIGNALURE OF FERSONAL REPRESENTATIVE	