MI-0827-1118

State of New Jersey • Department of the Treasury

DIVISION OF PENSIONS & BENEFITS

P.O. Box 295, Trenton, NJ 08625-0295

MEMBER AUTHORIZATION FORM

FOR USE AND DISCLOSURE OF PROTECTED AND PRIVATE INFORMATION

Member's Name: _____
Last *First* *MI*

Address: _____
Street *City* *State* *Zip*

Daytime Telephone Number: (_____) _____ Email:_____
Area Code

Member's Social Security Number: _____ Date of Birth _____/_____/_____
mm *dd* *yyyy*

By providing the information below and signing this form, I authorize the New Jersey Division of Pensions & Benefits (NJDPB) to release and/or disclose my protected and private information. Further, I understand that health information from the NJDPB can be provided to me but is otherwise Protected Health Information pursuant to the Privacy Rule of the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

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

The following is a specific description of the information I authorize be used and/or disclosed:

_____

_____

_____

I authorize my protected and private information to be used and/or disclosed for the following specific purposes:

_____

_____

_____

I authorize the following person(s) or organizations to receive my information from the NJDPB and to use or disclose such information for the purposes listed above. I understand that some or all of the information may no longer be protected by federal privacy standards.

_____

_____

_____

Expiration of Authorization. Upon release of the information described above, this authorization request will expire. Any future requests to release and/or disclose protected and private information will require a new *Member Authorization Form*.

MEMBER'S SIGNATURE

I have had an opportunity to review and understand the contents of this form. I have signed this form voluntarily and confirm that it accurately reflects my wishes regarding the use and/or disclosure of this information.

_____ Date _____/_____/_____
Member's Signature *mm* *dd* *yyyy*

If signed by a personal representative, complete the following:

Name of personal representative: _____

Relationship to member or nature of authority:_____
(e.g., health care power of attorney, guardian, other legal authorization — A copy of documentation must be attached.)

Address: _____
Street *City* *State* *Zip*

Daytime Telephone Number: (_____) _____ Email:_____
Area Code

_____ Date_____/_____/_____
Signature of Personal Representative *mm* *dd* *yyyy*

Return completed form to:
New Jersey Division of Pensions & Benefits
Office of Client Services
P.O. Box 295
Trenton, NJ 08625-0295