HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT
AUTHORIZATION

SECTION A: Individual authorizing use and/or disclosure

Name: ____

Address: ____

Telephone: ____________________________ Member ID Number (SSN) ____________________________

SECTION B: The use and/or disclosure being authorized
Protected Health Information (PHI) to be used and/or disclosed

Name of Patient: ____

Name of Providers/Facilities: ____

Dates of Service: ____

Entities or Persons Authorized to Use or Disclose: (Name or specifically describe the person(s) who are authorized to make use of and/or to disclose the PHI described above:

☐ Shareen Crosby, CUSD Benefits Department

☐ Conchita Waite, CUSD Benefits Department

☐ Other : ____

Purpose of this Authorization:

☐ At request of individual

☐ For the following purposes: ____

____

No Conditions: This authorization is voluntary. We will not condition your enrollment in a health plan, eligibility for benefits or payment of claims on giving this authorization.

Effect of Granting This Authorization: The PHI used or disclosed may be subject to re-disclosure by the recipient, in which case it may no longer be protected under the HIPAA Privacy Rule.

SECTION C: Expiration and Revocation

☐ This authorization will expire on ________/__________/_________

☐ This authorization will expire on occurrence of the following event (which must relate to the individual or to the purpose of the use and/or disclosure being authorized): ____

____

____

Right to Revoke: I understand that I may revoke this authorization at any time by giving written notice of my revocation to the Contact Office listed below. I understand that revocation of this authorization will not affect any action you took in reliance on this authorization before you received my written notice of revocation.

Contact Office: Clovis Unified School District Benefits Department
Telephone: (559) 327-9125
Fax: (559) 327-9123
Address: 1450 Herndon Avenue. Clovis, Ca 93612

INDIVIDUAL'S SIGNATURE:

I, ____, have had full opportunity to read and consider the contents of this authorization, and I understand that, by signing this form, I am confirming my authorization of the use and/or disclosure of my protected health information, as described in this form.

Print Name: ____

Signature: ____

Date: ____

If this authorization is signed by a personal representative on behalf of the individual, complete the following:

Personal Representative's Name: ____

Signature: ____

Date: ____

Relationship to Individual: ____