

# AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

*By completing this form, you are authorizing the disclosure and/or use of individually identifiable medical/dental/vision information.*

## EMPLOYEE/SUBSCRIBER INFORMATION (always complete employee information)

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Social Security Number \_\_\_\_\_ Trust Fund or Employer Name \_\_\_\_\_

## PATIENT INFORMATION (The person whose PHI will be used or disclosed)

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Date of Service \_\_\_\_/\_\_\_\_/\_\_\_\_ Provider Name \_\_\_\_\_ Type of Service \_\_\_\_\_

## SPECIFIC DESCRIPTION OF INFORMATION TO BE USED

\_\_\_\_\_  
 \_\_\_\_\_

## THE PLAN AND/OR PACFED BENEFIT ADMINISTRATORS IS AUTHORIZED TO:

Release (Use or Disclose) the information to:       Receive/ Obtain the information from:

Name _____	Title _____
Street Address _____	City _____ State _____ ZIP Code _____
(____) _____	(____) _____
Phone Number _____	Fax Number _____
_____	_____
Effective Date of Authorization _____	Termination Date of Authorization _____

## SPECIFIC PURPOSE OF THE DISCLOSURE

\_\_\_\_\_  
 \_\_\_\_\_

### Important Information about your rights.

I have read and understood the following statements about my rights:

- I may revoke this authorization at any time prior to its expiration date by notifying PacFed Benefit Administrators in writing, but the revocation will not have any affect on any actions that the Plan and/or PacFed took before it received the revocation.
- I may see and copy the information described on this form if I ask for it.
- I am not required to sign this form to receive my health care benefits (enrollment, treatment, or payment).

The information that is used or disclosed pursuant to this authorization may be redisclosed by the receiving entity. I have the right to seek assurances from the above-named persons/organizations authorized to receive the information that they will not redisclose the information to any other party.

For more information about your privacy rights, see the Notice of Privacy Practices available by sending a written request to the Plan's Privacy Officer at PacFed Benefit Administrators, 1000 N. Central Ave., Suite 400, Glendale, CA 91202.

If you believe your privacy rights have been violated, you may file a complaint with the Plan's Privacy Officer, at (818) 243-0222. You may also file a complaint with the Secretary of the Department of Health and Human Services. You will not be penalized for filing a complaint.

X \_\_\_\_\_  
 Signature of patient or representative – if representative, please give relationship

X \_\_\_\_\_  
 Date