NEW YORK STATE OF OPPORTUNITY. | **Department of Civil Service**

EMPLOYEE BENEFITS DIVISION
New York State Health Insurance Program (NYSHIP)
Authorization for Release of Health Information

EBD-543 (3/17)

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

NOTE: The only persons who can complete and sign this form to authorize the disclosure of personal information are:

- **The individual who is the subject of the information to be disclosed;**
- **A parent or legal guardian - only if the individual who is the subject of the information to be disclosed is a child under the age of 18; or**
- **A personal representative of the individual as designated through a Power of Attorney, Health Care Proxy, a court order, or other appropriate legal documentation.**

Part A – Identify the Person Whose Information is to be Released

Name: _____ Identification #: _____

Part B – Person(s) or Organization(s) Authorized to Receive Information

Please complete this section with the person(s) or organization(s) you are authorizing to receive information about the person named in Part A.

Name: _____

Street Address: _____

City, State, Zip: _____

Telephone: _____ E-mail: _____

Name: _____

Street Address: _____

City, State, Zip: _____

Telephone: _____ E-mail: _____

Possibility of Redisclosure: It is possible that the person or organization you have named to receive this information may redisclose the information and, if so, the information may no longer be protected by the federal privacy rules of the Health Insurance Portability and Accountability Act of 1996.

Part C – Information to be Released

The New York State Department of Civil Service - Employee Benefits Division (EBD) maintains information regarding eligibility for and enrollment in the New York State Health Insurance Program. This information includes, but is not necessarily limited to, names and identification numbers of all covered persons; health plan option (i.e. Empire Plan or the specific HMO in which you are enrolled); date of birth; address; premium and payment information; and employment information for purposes of determining eligibility. We do not maintain claims information or medical records.

☐ I authorize the release of information maintained by EBD as described above.

☐ I authorize the release of information maintained by EBD as described above with the following limitations:

(Please describe)

_____

_____

_____

_____

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Part D – Purpose of Disclosure

You must check one of the following to indicate a purpose for this release of information:

- ☐ Per my request
- ☐ To permit a family member or friend to act on my behalf
- ☐ Other _____

Part E – Expiration of Authorization

This authorization will remain in effect for twelve (12) months from the date of your signature unless another date or event that will cause the authorization to expire is specified below:

- ☐ When I am no longer enrolled in the New York State Health Insurance Program (NYSHIP)
- ☐ On (Date): _____
- ☐ When the following event occurs: _____

Terms for Termination/Revocation: You have the right to revoke this authorization at any time. However, your revocation will not affect any use or disclosure that we made in reliance upon your authorization before we learn of your revocation. You may revoke this authorization by writing to the NYSHIP Privacy Official at the address provided below.

Part F – Required Signature

I authorize release of the above-specified information. I understand that I am not required to sign this form in order to receive or to be eligible to receive health care benefits (enrollment, treatment, or payment).

_____ _____
Signature **Date**

_____ _____
Identification # **Telephone #**

If the person signing this form is not the individual whose information is being disclosed, please indicate your relationship to that person:

- ☐ Parent or legal guardian of a child under the age of 18
- ☐ Personal representative **(please attach documentation, i.e., Power of Attorney, Court Order, Health Care Proxy)**

Mail this form to the following address:

NYS Department of Civil Service - Employee Benefits Division
Albany, NY 12239

PLEASE KEEP A COPY OF THIS FORM FOR YOUR RECORDS.

Personal Privacy Protection Law Notification: The information you provide on this form is requested for the principal purpose of authorizing the use and/or disclosure of protected health information pursuant to 45 CFR 164.508. Failure to provide the information may interfere with our ability to use or disclose protected health information necessary to administer NYSHIP. The information will be maintained by the Director of the Employee Benefits Division (in the capacity as the HIPAA Privacy Official), Department of Civil Service, Albany, NY 12239. The information will be used in accordance with Public Officers Law section 96(1), also known as the Personal Privacy Protection Law. If you have any questions regarding this form or your insurance coverage, please call (518) 457-5754 or 1-800-833-4344 between the hours of 9:00 a.m. and 4:00 p.m. Monday through Friday.

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The attached EBD-543 form must be completed in its entirety. If you have any questions while completing the form please contact us at 1-800-833-4344.

Part A- This space requires providing the name and identification number of the New York State Health Insurance Program (NYSHIP) enrollee/subscriber (or dependent over the age of 18) if you wish to designate someone to be given information about you, put in **your** name and **your** social security number, or Survivor number, or COBRA number **or** your Alternate Identification number. The Alternate Identification number can be found on your Empire Plan health insurance card (If you are a dependent over the age of 18, you must note the identification number that you are covered under as well as your own social security number.) However, if you are enrolled in an HMO, please do not use your HMO identification number.

Part B- This section must be completed with the name(s) of person(s) or organizations you wish to authorize the Employee Benefits Division's release of information to concerning your health insurance enrollment record.

Part C- Information to be Released: You must check one of the two options. If you check the second option, you must describe any limitations you wish to place on information that you are permitting to be disclosed.

Part D- Purpose for Release of Information: You must place a check at least one of the boxes. If you choose "Other", you must write in the purpose for the release of information. Checking "Per Your Request" will require submission by you of a request for each instance you wish the Employee Benefits Division to release information.

Part E – If you do not complete this section, the authorization will only remain in effect for one year from the signed document. If you place a check mark in front of "when the following event occurs:" you **must** designate an event; for example, "as long as I am covered in the NYSHIP," or "as long as I live."

Part F- You must sign and date the document; provide your identification number and your telephone number. If you are the parent or legal guardian of a child under the age of 18 check the "Parent or legal guardian of a child under the age of 18" box. If you are completing and signing this form as a representative for the enrollee (including a parent of a disabled child over the age of 18), you **must** provide documentation enabling you to act on that person's behalf. Such documentation might include, but not be limited to, a Power of Attorney or Court Order. Absence of required documentation will render this Authorization for Release of Health Information ineffectual.