



BOCES Southern Westchester

THE BOARD OF COOPERATIVE EDUCATIONAL SERVICES

AUTHORIZATION FOR RELEASE OF MY INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION

Employee Name _____ Employee ID No. _____

I hereby authorize the use and/or disclosure of my individually identifiable health information, effective on receipt of this Authorization by the Plan Administrator, as follows:

(Identify the specific person or organization authorized to provide that information)

- ___ Employer
- ___ Health Plan Carrier (specify):
- ___ Medical; ___ Prescription Drug; ___ Dental; ___ Vision; ___ Health Care FSA
- ___ Disability Plan (specify): ___ STD; ___ LTD
- ___ Group-Term Life Plan
- ___ Other(specify): _____

(Identify the specific person or organization authorized to receive that information.)

(Describe the information to be used or disclosed in a specific and meaningful manner.)

(Describe each purpose of your request. If you don't want to, check the box below.)

_____ I do not choose to describe the purpose of my request.

Expiration Date or Event. Unless revoked by me as described below, this authorization will expire as of:

Date: _____ (You must indicate a specific expiration date here or event below.)

Event:

___ Termination of employment of the employee identified above.

___ Other Event (Specify): _____

Right to Revoke This Authorization: I understand that:

- I have the right to revoke this authorization at any time by notifying the Plan Administrator Southern Westchester BOCES in writing at 17 Berkley Drive, Rye Brook, NY 10573, or by using the revocation at the bottom of this form.
- My revocation will become effective only after the Plan Administrator receives it.
- This revocation will not affect any use or disclosure of my information made pursuant to this authorization before the Plan Administrator receives my written revocation.

I understand the following:

- Federal law might not protect the information once it is disclosed pursuant to this authorization.
- The Health Plan(s) may not condition my health care treatment or my eligibility, enrollment or payment of benefits on whether I or any other member of my family sign this authorization.
- I am entitled to receive a copy of this authorization.

Date: _____ Signature: _____

(Check One): ___ Employee; ___ Spouse; ___ Dependent Child

I acknowledge receipt of a copy of this authorization:

Date: _____ Signature: _____

I hereby revoke this authorization as of the date the Plan Administrator receives this document:

Date: _____ Signature: _____