Pension Boards
United Church of Christ

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UCC Medical and Dental Benefits Plan

Authorization to Release Protected Health Information (PHI)

****IMPORTANT NOTE****

Unless the authorization is expressly limited, this authorization grants the right to release protected health information as described herein, including information about any diagnosis or treatment for any mental health (excluding psychotherapy notes), substance abuse, sexually transmitted disease (such as HIV), cancer and/or genetic condition.

1. Person Authorizing the Release of Protected Health Information

_____

_____

_____

[PRINT NAME, DATE OF BIRTH AND ADDRESS OF INDIVIDUAL OR, IF MINOR OR PERSONAL REPRESENTATIVE INVOLVED, NAME OF MINOR AND GUARDIAN OR PERSONAL REPRESENTATIVE]

2. Specific Purpose for This Authorization

I authorize the release of my protected health information for the following purpose(s):

_____

_____

_____

[LIST SPECIFIC PURPOSES HERE]

3. Specific Description of Protected Health Information to Be Used or Disclosed

A. _____ My complete protected health information record maintained by or on behalf of the PBUCC Medical, Dental and Vision Plan

_____/_____/_____

B. _____ Only the following protected health information (e.g., for certain medical services rendered on or after a specified date):

_____

_____

_____

[SPECIFICALLY DESCRIBE THE INFORMATION TO BE USED OR DISCLOSED, INCLUDING, BUT NOT LIMITED TO, MEANINGFUL DESCRIPTORS SUCH AS DATE OF SERVICE, TYPE OF SERVICE PROVIDED, LEVEL OF DETAIL TO BE RELEASED, ORIGIN OF INFORMATION, ETC.]

4. Name of Person or Entity to Whom Protected Health Information May Be Disclosed

_____

_____

_____

[PRINT NAME(S) OF INDIVIDUAL(S) OR ORGANIZATION(S) TO RECEIVE INFORMATION]

5. DURATION OF AUTHORIZATION

This authorization shall be in force and effect until:

_____

_____

[SPECIFY (1) DATE OR (2) EVENT THAT RELATES TO THE PATIENT OR THE PURPOSE OF THE USE OR DISCLOSURE]

6. RIGHT TO REVOKE AUTHORIZATION

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to:

Chief Audit and Compliance Officer
The Pension Boards–United Church of Christ, Inc.
475 Riverside Drive
Room 1020
New York, NY 10115

7. ACKNOWLEDGEMENT OF PRIVACY RIGHTS

I understand that:

- This authorization is voluntary and I may refuse to sign it.
- I may revoke this authorization at any time prior to its expiration date by sending a written revocation notice to each entity that I previously authorized to disclose health information; however, a revocation is not effective with respect to any actions taken by the parties named in this authorization prior to the receipt of the revocation;
- Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law; and
- I am not required to sign this authorization as a condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable).

I understand that I have the right to:

- Inspect or copy the protected health information to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights); and
- Refuse to sign this authorization.

_____ _____/_____/_____

Print Name of Plan Participant Above **Date**

_____

Signature of Plan Participant, Patient or Personal Representative

_____

Description of Personal Representative's Authority