Chicago Benefit Office
Authorization Form for the Use and Disclosure of Protected Health Information

Plan Participant's Name: ________________________ **City Employee Name: ______________________**

Plan Participant's Date of Birth: __________________ **City Employee ID No: _______________________**

By signing this Authorization form, I understand that I am authorizing the Chicago Benefits Office to use and disclose my protected health information (PHI), as described in more detail below, to the following person(s) or organization(s):
Name of person(s) or organization(s):

Telephone Number: _________/_________/_________ *Fax Number (optional)__________/__________/__________*

I authorize the use and disclosure of the following PHI (check all that apply):
☐ *Enrollment / Disenrollment Information*
☐ *Other Information (describe):*

For the following: ☐ *Myself* ☐ *My minor dependent: (Print names):*
☐ *A person for whom I am the personal representative*

State the purpose of this request below:
____
____
____

This authorization expires upon the termination of Participant's participation in the City's group health benefits or, if later, upon the date that is one year after it is signed or such other date as specified here:_____________________.

I understand that I may revoke this authorization at any time by notifying the Chicago Benefits Office in writing. However, I understand that such a revocation will not have any effect on any information already used or disclosed before the Chicago Benefits Office received and logged the written notice revocation.

I understand that there is a potential that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and will no longer be protected by the Health Insurance Portability and Accountability Act.

This Authorization is voluntary, and I may refuse to sign this Authorization form.

I understand that the Chicago Benefits Office may not condition payment, enrollment, or eligibility for health plan benefits on whether I sign this authorization.

I understand that I have a right to inspect and copy the information for which I am authorizing disclosure.

Signature of participant/parent of child/Personal Representative

Printed name of person signing

Relationship to participant (if not signed by participant)

Personal Representative:

If the person signing this form is the Personal Representative of the Participant, sign below:

I swear under penalty of perjury that I am the Personal Representative of the Participant named above.

Participant's Personal Representative (Print Name): Date Signed:

Please state status (for example: legal guardian, Power of Attorney):

Signature of Personal Representative:

Daytime Telephone No.: _______ /____________/____________

Address:____

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If a Personal Representative executes this form, please attach copy of document, if applicable, which creates the status as personal representative, such as Legal Guardianship, General Power of Attorney, or Power of Attorney for Health Care Matters.