



EMPLOYEE AUTHORIZATION REQUEST FORM

You may give the City of Salisbury written authorization to disclose your protected health information (PHI) to anyone that you designate and for any purpose. If you wish to authorize a person or entity to receive your PHI, please complete the information below.

EMPLOYEE OR DEPENDENT WHO'S INFORMATION WILL BE DISCLOSED:

MONTH/DAY/YEAR

□□/□□/□□□□

FIRST NAME

M.I.

LAST NAME

DATE OF BIRTH

At my request, I authorize the City of Salisbury to disclose Protected Health Information to (enter the name of person/entity who will receive member's PHI):

FIRST NAME

M.I.

LAST NAME

RELATIONSHIP TO EMPLOYEE OR COVERED DEPENDENT

Please provide the following information to the person you have authorized so that we may verify the person's identity and authority to receive your PHI: a.) your employee number, b.) your social security number, c.) your date of birth, d.) your address.

I authorize the City of Salisbury to disclose the following PHI to the person/entity listed above. CHECK ONLY BOXES THAT APPLY:

- All Information Requested
- Enrollment Information
- Benefit Information
- Premium Payment Information
- All Claims Information
- Flex Medical Information

I would like this authorization to expire on

MONTH/DAY/YEAR

□□/□□/□□□□ or at the resolution of this inquiry.

I understand that I may revoke this authorization at any time by giving the City of Salisbury written notice mailed to the address below. However, if I revoke this authorization, I also understand that the revocation will not affect any action the City of Salisbury took in reliance on this authorization before the City of Salisbury received my written notice of revocation.

I also understand that the City of Salisbury will not condition the provision of health related benefits on this authorization.

I also understand that if the persons or entities I authorize to receive my PHI are not health plans, covered health care providers or health care clearinghouses subject to the Health Insurance Portability and Accountability Act (HIPAA) or other federal health information privacy laws, they may further disclose the PHI and it may no longer be protected by HIPAA or federal health information privacy laws.

Signature: _____

MONTH/DAY/YEAR

□□/□□/□□□□

If signed by an individual other than the employee: _____

PRINT YOUR FULL NAME

(Describe your authority to act for the member e.g., power of attorney, court order, parent of minor child, etc.)
