County of Chemung Insurance Department

Authorization Form

I hereby authorize the use or disclosure of protected health information as follows:

1. The person whose information may be used or disclosed is:

   Name: _____
   Address: _____
   City:_____ State: _____ Zip Code:_____
   Subscriber ID Number: _____* Date of Birth: _____

   **The County of Chemung Insurance Department is requesting your Subscriber ID Number for the purpose of identification to expedite your request on this form. While compliance with this request is voluntary, failing to furnish your Subscriber ID Number to the County of Chemung Insurance Department may create delays with your request on this form.*

2. The information that may be used or disclosed includes (*check all that apply*):

   Claim Information

   Membership Information

   Benefit Information

   Payment Information

   Other (*describe*): _____

   Exclude the following information: _____

3. This information may be disclosed by:
   Chemung County Insurance Department and Business Associates

4. The information may be disclosed to: (*Multiple names/entities may be listed if all other information on this authorization is identical for each name/entity listed*.)

   Name of person or entity: _____
   Address: _____
   City:_____ State: _____ Zip Code:_____

   Name of person or entity: _____
   Address: _____
   City:_____ State: _____ Zip Code:_____

   Name of person or entity: _____
   Address: _____
   City:_____ State: _____ Zip Code:_____

5. The purpose of disclosure is:

   Request of the individual who is the subject of the record or his/her personal representative;

   Other (*describe*): _____

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6. This authorization expires upon the earlier of (*check applicable box*):

Upon my disenrollment from the Chemung County Health Insurance Plan or if later, the date that claims incurred by me while enrolled have been finalized; or

Upon completion of the requested disclosure; or

On _____ (*specific date*).

7. It is understood that this authorization may be revoked at any time. To revoke this authorization, a written request should be made to the Department Head of the County of Chemung Insurance Department or his or her designee. Information disclosed before an authorization is revoked may not be retrieved. If action was taken in reliance on this authorization, the County of Chemung Insurance Department may continue to use or disclose protected health information as needed to complete the work that began because the authorization was given.

8. It is understood that information used or disclosed pursuant to this authorization may be re-disclosed by the recipient of the information. Most health care providers and all health benefit plans must follow federal rules protecting the privacy of health information. But those rules may not apply to other organizations.

I am the person whose records will be used or disclosed. I understand and agree to this authorization.

_____ _____
Signature Date

_____
Print Name

OR

I am the "personal representative" (*as defined in the Notice of Privacy Practices for Protected Health Information*) of the person whose records will be used or disclosed. My relationship to that person is _____.

I understand and agree to this authorization.

_____ _____
Signature Date

_____
Print Name

A personal representative will be required to provide legal proof of representation such as power of attorney.

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