The California State University
Authorization to Use and/or Disclose Personal Health Plan Information

[redacted]

Form Received By _____ **Date** _____

1. Employee Name	**1a. Employee Health Plan ID Number**
1b. Employee Date of Birth	**1c. Employee Address and Phone Number**
2. Name of Person Whose Health Information is the Subject of this Authorization	**2a. Relationship to Employee** Self ☐ Spouse ☐ Child ☐ Other ☐
3. Your Name	**3a. Authority** **If you are not the person in Box 2, please describe your authority to act on his or her behalf:** _____ _____ _____
4. Mailing Address for Records	**4a. City, State, Zip Code**

I hereby authorize _____ [Insert name of the insurance carrier, HMO, health plan vendor or the CSU Group Health and HCRA Plans who will be disclosing the health information] to use and/or disclose the health information described in Sections A — E below.

Section A: Health Information to be Used and/or Disclosed.

Specify the health information to be released and/or used, including (if applicable) the time period(s) to which the information relates. Select only one (1) of the following boxes:

☐ All of my health information, including, but not limited to, dates of service, types of service, treatment charts, x-rays, provider notes or other information, related to the following health condition: _____ (please describe).

☐ All of my health information relating to Claim Number _____, including, but not limited to, dates of service, types of service, treatment charts, x-rays, provider notes or other information.

☐ Other (please specify). _____

_____

Section B: Person(s) Authorized to Use and/or Receive Information.

Specify the persons or class of persons authorized to use and/or receive the health information described in Section A:

_____.

Section C: Purposes for Which Information will be Used or Disclosed.

Specify each purpose for which the health information described in Section A may be used or disclosed. Select all of the applicable boxes below:

☐ To facilitate the resolution of a claim dispute.

☐ As part of my application for leave under the Family and Medical Leave Act (FMLA) or state family leave laws.

☐ For a disability coverage determination.

☐ At my request.

☐ Other (please specify)._____

Section D: Expiration of Authorization

Specify when this Authorization expires. (Provide a date or triggering event related to the use or disclosure of the information.)

☐ On the following date: _____.

☐ Upon the passage of the following amount of time: _____.

☐ Upon my disenrollment from the CSU Group Health and HCRA Plans.

☐ Upon my return from FMLA leave.

☐ Other (please specify) _____

Your rights:

- You can revoke this Authorization at any time by submitting a written revocation to the campus benefits office.
- A revocation will not apply to information that has already been used or disclosed in reliance on the Authorization.
- Once the information is disclosed pursuant to this Authorization, it may be redisclosed by the recipient and the information will no longer be protected by HIPAA.
- The Plan may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign the Authorization.
- You will be provided with a copy of this Authorization Form, after signing, if the Plan sought the Authorization.

Signature of Participant **Date**