Employee Benefit Trust

HIPAA Authorization for Use or Disclosure of Protected Health Information (PHI)

This authorization, unless limited below or subsequently revoked, grants the Christian Brothers Employee Benefit Trust (CBEBT) the right to use or disclose all personal medical information including medical information about any diagnosis or treatment for any mental health, substance abuse, sexually transmitted diseases, cancer and/or genetic condition.

Please complete the entire form and return it to CBEBT at 1205 Windham Parkway, Romeoville, IL 60446-1679 or fax it to 630.378.3005.

Individual Whose Information is to be Disclosed

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

CBEBT ID Number (as displayed on your ID Card): _____

Name of Person(s) Information can be Disclosed to

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Information to be Disclosed

☐ Complete medical record

☐ Complete medical record for services rendered on or after the following date: _____

☐ Only the following medical information. 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.

_____

_____

Acknowledgement of Privacy Rights

I understand that:

- A revocation is not effective to the extent that the parties named in this authorization have relied on the use or disclosure of the protected health information prior to the receipt of the revocation;
- That information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law; and
- My health care provider(s) and health plan(s) may not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure.

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).
- Revoke authorization, in writing, at any time.
- Refuse to sign this authorization.

_____ _____

Signature of individual requesting disclosure (or Personal Representative) Date
If Personal Representative, please attach appropriate documentation.

_____

If Minor, Print Name of Plan Member

_____

Description of Personal Representative's Authority, if Applicable