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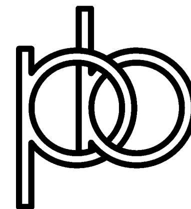

# UCC Medical and Dental Benefits Plan
# Authorization to Allow the Use or Disclosure of Protected Health Information (PHI)

**IMPORTANT NOTE**

Unless the authorization is expressly limited, this authorization grants the health care provider the right to use or disclose all personal medical information for the purpose described, including medical information about any diagnosis or treatment for any mental health, substance abuse, sexually transmitted disease (such as HIV), cancer and/or genetic condition.

**1. Person Authorizing the Release of Protected Health Information**

________________________________________________

________________________________________________

________________________________________________

[PRINT NAME AND ADDRESS OF INDIVIDUAL OR, IF MINOR OR PERSONAL REPRESENTATIVE INVOLVED, NAME OF MINOR AND GUARDIAN OR PERSONAL REPRESENTATIVE]

**2. Name of Medical Service Provider Presently Holding the Protected Health Information (the Health Care Provider)**

________________________________________________

________________________________________________

________________________________________________

[PRINT NAME AND ADDRESS OF PHYSICIAN, HOSPITAL OR HEALTH CARE PROVIDER]

**3. Reason for This Authorization**
***I authorize the use or disclosure of the medical information for the following purposes:***

________________________________________________

________________________________________________

________________________________________________

[LIST SPECIFIC PURPOSES HERE]

**4. Authorization and Description of Medical Information to Be Used or Disclosed**
***I authorize the health care provider(s) listed in Section 2 above to use and/or disclose the following personal medical information to the person or entities listed in Section 5 for the purposes described in Section 3:***

A. _____ The complete medical record for services rendered on or after the following date:
__________/__________/__________

B. _____ 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.]

5. **Name of Person to Whom Information May Be Disclosed**
***I authorize the release of the medical information described in Section 4 to the following person(s) or organization(s):***

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________
[PRINT NAME(S) OF INDIVIDUAL(S) OR ORGANIZATION(S) TO RECEIVE INFORMATION]

6. **DURATION OF AUTHORIZATION**
***This authorization shall be in force and effect until:***

______________________________________________________________________

______________________________________________________________________
[SPECIFY (1) DATE OR (2) EVENT THAT RELATES TO THE PATIENT OR THE PURPOSE OF THE USE OR DISCLOSURE]

7. **RIGHT TO REVOKE AUTHORIZATION**
***I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to:***

General Counsel and Corporate Secretary
The Pension Boards–United Church of Christ, Inc.
475 Riverside Drive
Room 1020
New York, NY 10115

8. **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 redisclosure 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); and
   - refuse to sign this authorization.

__________________________________________________ ________/________/________
**Print Name of Plan Participant Above** **Date**

__________________________________________________
**Signature of Plan Participant, Patient or Personal Representative**

__________________________________________________
**Description of Personal Representative's Authority**