CalPERS

The CalPERS Long-Term Care Program

Authorization for Use & Disclosures of Protected Health Information

to an Authorized Individual/Personal Representative

Coverage ID: 41-_____

Participant Name: _____

I, _____, hereby authorize the use and disclosure of my protected health information for: coverage administration, billing information, and or claims information, or as defined, or as limited to the following:_____

_____

_____

CalPERS Long-Term Care Program may release my protected health information as described above to the following person(s):

_____ _____ (___)_____

Printed Name of Authorized Individual **Relationship** **Phone Number**

_____

Street Address

_____

City State Zip Code

This form is for use and disclosures only; it does not authorize anyone other than me or my legal representative to make any changes to my: coverage, billing or demographic information. I understand that if the person or entity that receives my information is not covered by federal privacy regulations, my information may be re-disclosed by such person or entity, and will then no longer be protected.

This authorization is valid until my coverage ends, unless a specific expiration dates or event is specified here: _____. I understand that I may revoke this authorization in writing at any time. I am entitled to make a copy of, or request to receive a copy of this authorization.

I understand that I am not required to sign this authorization and that payment or eligibility will not be conditioned upon my choice not to sign. I further understand that my protected health information cannot be disclosed to any unauthorized individual without my signature.

I acknowledge by my signature below that I have read and understand this Authorization, it accurately reflects my wishes, and a photocopy, facsimile, or other electronic copy is as valid as the signed original.

_____

Signature of Participant/Insured or *Legal Representative Date

*If you are signing as a legal representative, describe the scope of your authority to act on their behalf and include a copy of the documentation of your legal authority.

Mail or fax completed form and attachments to:

CalPERS Long-Term Care Program
PO Box 64902
St. Paul, MN 55164-0902
Fax: (866) 294-6966