JOANNE M. MAHONEY
County Executive

COUNTY OF ONONDAGA

JAMES J. ROWLEY
Chief Fiscal Officer

MARK R. STASKO
Director of Risk Management

ROBERT BRATEK
Director of Loss Control

DENISE DOWNING
Employee Benefits Manager

DEPARTMENT OF FINANCE

DIVISION OF RISK MANAGEMENT
John H. Mulroy Civic Center, 15th Floor
421 Montgomery Street
Syracuse, New York 13202-2903
(315) 435-3498 Fax (315) 435-2869
www.ongov.net

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Please complete the following information. All sections must be completed or the form will be considered incomplete and be returned to you.

1. The Individual

Name: ____
Address: ____
City: ____________________ **State:** _____________ **Zip:** ___________
Member Identification Number: __________________________________
Birth Date: ________________

2. Purpose of this Authorization: Please note, that by signing this form, you will authorize Onondaga County Risk Management to disclose your protected health information for the following purposes. Please check one.

____ **Any Purpose**
____ **Any Purpose Excluding Mental Health or HIV**
____ **Specific Medical Condition** __________________________________

3. Protected Health Information to Be Disclosed: Please indicate the specific protected health information you authorize us to disclose. Please check all that apply:

____ **Claim Information (e.g. status, type of service, diagnosis, provider, dates of service, etc.)**
____ **Membership Information (e.g. coverage information, enrollment dates, eligibility, address, dates of birth, etc.)**
____ **Benefit Information (e.g. benefits available, benefits used, contract limits, etc.)**
____ **Medical Records (e.g. physician or hospital records, case** management, etc.)

4. Entity Authorized to Receive: Please indicate the person's name and address to whom you are authorizing Onondaga County Risk Management to disclose the protected health information described above:

Name: ____ **Address:**
____ **City:** ____________________
State: _____________ **Zip:** ______________

5. Onondaga County Risk Management is required by law to protect your health information. By signing this document, you authorize Onondaga County Risk Management to use and/or disclose (release) your health information. Those persons who receive your health information may not be required by Federal privacy laws (such as the Privacy Rule) to protect it and may share your information with others without your permission, if permitted by laws governing them.

6. Signature: You may refuse to sign this authorization. However, without a signature, the authorization is not valid.

I, (please print) ________________________________, have had full opportunity to read and consider the contents of this authorization. I understand that, by signing this form, I am confirming my authorization that Onondaga County Risk Management may disclose to the person named in this form the protected health information described in this form. I understand that this authorization is only valid while enrolled in my current group.

I understand that I may revoke this authorization at any time by giving written notice of revocation to the office listed below. Revocation of this authorization will not affect any action taken in reliance on this authorization before written notice of revocation is received.

Signature: ________________________ Date: ____________________

If a personal representative on behalf of the individual signs this authorization, please complete the following:

Personal Representative's Name: (please print) ____________________
Description of Authority: ____
Personal Representative's Signature: ______________________________
Date:____

A personal representative must provide legal proof of representation, e.g. power of attorney.

Please complete and return this form to:
Onondaga County Risk Management
421 Montgomery Street 15th Floor
Syracuse, NY 13202