PLEASE RETURN THIS COMPLETED FORM TO:
Office of Clinical Management
The Episcopal Church Medical Trust
19 East 34th Street
New York, NY 10016
(Confidential Fax: 212.251.8891)

AUTHORIZATION
FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

1. INDIVIDUAL AUTHORIZING USE OR DISCLOSURE

_____
_____
_____
[Print name and address of individual who is the subject of the information.]

2. HEALTH PLAN(S) SPONSORED BY CHURCH PENSION GROUP SERVICES CORPORATION MAINTAINING THE RECORDS THAT ARE TO BE USED OR DISCLOSED (each Health Plan)

_____
_____
_____
[Print name and address of each health plan or other specific description]

3. DESCRIPTION OF PROTECTED HEALTH INFORMATION TO BE USED OR DISCLOSED*

_____
_____
_____
_____
_____
[Specifically describe the information to be used or disclosed. Include meaningful details such as date of service, type of service provided, level of detail to be released, origin of information, etc. Attach additional sheets, if necessary.]

***IMPORTANT NOTE: Unless the authorization is expressly limited, this authorization grants the Health Plan(s) the right to use or disclose ALL of the protected health information identified, including information about any diagnosis or treatment for any medical health, substance abuse, infectious disease (such as HIV/AIDS), cancer, mental health and/or genetic condition, for the purposes described.**

4. PERSON(S) TO WHOM INFORMATION MAY BE DISCLOSED

_____
_____
_____
[Print name of individuals or organizations to receive information, if any.]

5. PURPOSE OF AUTHORIZATION TO USE OR DISCLOSE

_____
_____
_____
_____
[List specific purposes here.]

6. DURATION OF AUTHORIZATION

_____

_____

_____

[Specify when authorization will expire by listing (1) a date or (2) an event that relates to the patient or the purpose of the use or disclosure.]

7. TO REVOKE THIS AUTHORIZATION, CONTACT:

Office of Clinical Management
The Episcopal Church Medical Trust
19 East 34th Street
New York, NY 10016
(Confidential Fax: 212.251.8891)

8. AUTHORIZATION AND ACKNOWLEDGEMENT OF PRIVACY RIGHTS

I authorize the Health Plan or Plans identified in item 2 to use and/or disclose the protected health information, as defined under the privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996, described in item 3 to the persons listed in item 4 for the purposes described in item 5. This authorization shall remain in force and effect until the date or event specified in item 6 unless I furnish written notice of revocation to the person specified in item 7.

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;
- 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, except in certain circumstances. For example, if the purpose of a test or exam is to produce a record for my employment, I may be required to complete this authorization form before the test or exam is performed.

_____ _____

Signature of Individual or Personal Representative Date

If a personal representative is signing the form on behalf of the individual whose protected health information is to be used or disclosed, please print the name of the personal representative and describe his or her authority to act on behalf of the individual.

_____

*[Name of Personal Representative]**

_____

_____

_____

[Authority of Personal Representative]

*Personal representative includes:

- Person who (1) has health care power of attorney, or (2) is the parent or legal guardian of a minor.
- If you are not (1) or (2) above, identify your relationship to the individual and your involvement in the individual's health care. The plan sponsor will determine whether disclosure to you is in the best interest of the individual.

Note to Individual: The decision of whether to accept this authorization is made solely by the person or entity whom you are authorizing to disclose information.