



# HIPAA Health Plan Participant Authorization Form

Please complete and sign this form. (Note that a separate authorization must be used if the authorization is for psychotherapy notes.) **Send it to:** Privacy Officer, Columbia University Human Resources, 615 West 131<sup>st</sup> Street, 4<sup>th</sup> Floor, New York, NY 10027. **Fax it to:** (212) 851-7026.

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Address: \_\_\_\_\_ Apt. #: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Home Phone: ( ) - Work Phone: ( ) -

E-Mail: \_\_\_\_\_ Date of Birth (mm/dd/yyyy): / /

Participant ID Number and/or Social Security Number: \_\_\_\_\_

By signing this authorization form I authorize the person(s) and/or organization(s) described below to use and/or disclose my health information (information that constitutes protected health information as defined in the Privacy Rule of the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996) in the manner described below. I understand that I am under no obligation to sign this form. The person(s) and/or organization(s) described below whom I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan, or eligibility for health care benefits on my decision to sign this authorization, except as follows:

A health plan may condition enrollment in the health plan or eligibility for benefits on this authorization if I am not yet enrolled in the health plan, if the purpose of this authorization is to allow the health plan to obtain the information it needs to make an eligibility, enrollment, underwriting or risk rating determination, and if psychotherapy notes are not requested. If I refuse to sign this authorization I may be denied enrollment in the health plan or eligibility for health care benefits.

I have signed this form voluntarily to document my wishes regarding the use and/or disclosure of the health information described below in Section 1 of this form.

## 1. Description of Health Information I Authorize to be Used or Disclosed

The following is a specific description of the health information I authorize be used and/or disclosed:  
(Specify and provide a meaningful description. If you need more space, please attach a sheet of paper.)



## 2. Persons/Organizations Authorized to Use and/or Disclose My Health Information

I authorize the following person(s) and/or organization(s) (or classes of persons and/or organizations), including the Health Plan, to use and/or disclose the health information described above in Section 1 of this form.

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## 3. Persons/Organizations Authorized to Receive and/or Use My Health Information

I authorize the following person(s) and/or organization(s) (or classes of persons and/or organizations) to receive my health information from the person(s) and/or organization(s) described in Section 2 above and to use or disclose such information for the purposes listed below in Section 4 of this form. I understand that if the person(s) and/or organization(s) listed below are not health care providers, health plans or health care clearinghouses subject to federal privacy standards, the health information disclosed pursuant to this authorization may no longer be protected by the federal privacy standards and such person(s) and/or organization(s) may redisclose my health information without obtaining my authorization.

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## 4. Description of Each Purpose for the Requested Use and/or Disclosure

I authorize my health information to be used and/or disclosed for the following specific purposes:

*(If you need more space, please attach a sheet of paper.)*



### 5. Your Rights with Respect to This Authorization

**5.1 Right to Revoke.** I understand that I have the right to revoke this authorization at any time. I also understand that my revocation of this authorization must be in writing. **To obtain a copy of an authorization revocation form I may contact the Policy Officer by writing to: Columbia University Human Resources, 1901 Interchurch Center, 475 Riverside Drive, Mail Code 7705, New York, NY 10115 or by telephone at: (212) 870-2571.** I am aware that my revocation will not be effective as to uses and/or disclosures of my health information that the person(s) and/or organization(s) identified in Sections 2 and 3 of this form have already made in reliance upon this authorization.

**5.2 Right to Receive Copy of This Authorization.** I understand that if I agree to sign this authorization, which I am not required to do, I must be provided with a signed copy of it.

### 6. Expiration of Authorization

This authorization will expire (choose and complete one):

On: Date of Birth (mm/dd/yyyy):   /  /  

Upon the occurrence of the following event(s) related to my health care or to the purpose(s) for which I have authorized the use and/or disclosure of my health information described in Section 4 of this form:  
(If you need more space, please attach a sheet of paper.)

### Signature

I, \_\_\_\_\_ (please print name),  
have had an opportunity to review and understand the contents of this form. By signing this form, I am confirming that it accurately reflects my wishes.

Participant Signature: \_\_\_\_\_ Date (mm/dd/yyyy): \_\_\_\_\_

**If signed by a personal representative, complete the following:**

Name of Personal Representative: \_\_\_\_\_

Relationship to participant or nature of authority (e.g., health care power of attorney, guardian, other statutory authorization): \_\_\_\_\_

Address: \_\_\_\_\_ Apt. #: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Home Phone: (    ) - \_\_\_\_\_ Work Phone: (    ) - \_\_\_\_\_

E-Mail: \_\_\_\_\_