City of Milpitas

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

COMPLETE ALL SECTIONS, DATE AND SIGN

I, _____ , hereby voluntarily authorize the disclosure of protected health information as described below:

The information is to be disclosed by:	And is to be provided to the following recipient:
HEALTH PLAN PROVIDER	NAME OF PERSON AUTHORIZED TO RECEIVE THE DISCLOSED INFORMATION **City of Milpitas – Human Resources**
STREET ADDRESS	STREET ADDRESS **455 E. Calaveras Blvd.**
CITY/STATE/ZIP CODE	CITY/STATE/ZIP CODE **Milpitas, CA 95035**

Protected Health Information (PHI) to be used or disclosed: [check appropriate box(es)]

- ❑ Information necessary to identify me including but not limited to, my name, address, telephone number, social security or other identification number or other health information as listed below:
- ❑ Information relating to the healthcare services provided to me, including but not limited to date of service, type of service, treatment chart, x-rays, medical notes or other information as listed below:
- ❑ Information relating to the payment for the healthcare services including but not limited to healthcare payment, my payment or co-payment and total or aggregate payment or other information as listed below:
- ❑ Information relating to my eligibility for benefits, including but not limited to enrollment, contribution or payment of the premium for healthcare benefits or other information listed below:

_____

_____

_____

My protected health information will be used/disclosed for the following purpose(s):

_____

_____

_____

I understand that I have the right to revoke this authorization. I understand that my request to revoke this authorization must be in writing and can be mailed to:

City of Milpitas
Attn: Human Resources
455 E. Calaveras Blvd.
Milpitas, CA 95035

I understand that my protected health information may be subject to re-disclosure by the recipient and is no longer protected by the privacy regulations issued pursuant to the Health Insurance Portability and Accountability Act of 1996.

This authorization is valid for one (1) year from the following date: _____

Please complete all applicable information.

Enrollee Name: _____ Social Security Number: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Signature: _____ Date: _____