AUTHORIZATION FOR

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Your privacy is important to Ball State University. As a result, we ask you to complete the following Authorization related to your personal health and health-related benefits.

I hereby authorize use and disclosure of protected health information (PHI), as described below. (*Please complete legibly*.)

This Authorization relates only to the PHI of:	4. This Authorization only permits use and disclosure of PHI to the following person(s) or classes of persons (include the names or descriptions of persons to whom the PHI may be given.)
Name: (Duint)	
(Print)	
Last four digits of Social Security Number:	
 1. This authorization applies only to the following PHI (Check one, and provide a description of specific PHI to be disclosed if you choose the second option, such as information related to a specific diagnosis or claim and/or particular dates.) All information pertaining to any of my health benefit claims under the Ball State University (BSU) health benefit plan(s), from the date my coverage under the plan(s) began until the expiration or revocation of this Authorization. 	5. This Authorization expires (check one and specify a date or event upon which the authorization will end if you choose one of the last two options.)
	☐ When my employment and/or benefit coverage with BSU terminates
	☐ One year from date of this Authorization
	☐ On the following date:
Only the following PHI:	☐ Upon the occurrence of the following event:
2. This Authorization permits use or disclosure by the BSU Office of Payroll and Employee Benefits of PHI maintained by	I have read and understand the following statements about my rights:
the following BSU health care or health related plans: (check all that apply) Any health plan in which I am enrolled at the time the request is made and prior to the expiration date or revocation of this Authorization. (Health plan includes dental.)	a. I may revoke this authorization at any time by giving written notice to the Ball State University Office of Payroll and Employee Benefits. I understand that my revocation
	will not affect any use or disclosure of my PHI that was made in reliance on the authorization before I revoked it.
	b. My health plan cannot require me to sign this authorization in order to be eligible for coverage, to enroll
☐ Any applicable disability plan (Long Term Disability, Short Term Disability, or other salary continuation benefit related to health matters).	in the plan, or to receive benefits or treatment. c. It is possible that the persons who receive information based on this authorization may disclose it to others and as a result the information may no longer be protected by federal privacy rules.
☐ Flexible Benefits Plan (including Flexible Spending Accounts, premium conversion plan, Heathcare Savings Account, or any other Flexible Benefits Plan in which I participate).	
	d. This Authorization for my personal health information does not apply to the release of the same information for any spouse or child over 18 that I may cover under
3. This Authorization only permits use and disclosure of PHI for the following purpose(s):	Ball State University medical benefits. I understand that my spouse or child over 18 must provide independent Authorization for release of their personal PHI.
☐ For any reason or purpose.	
$\hfill \square$ For only the following specific reason or purpose(s): _	I acknowledge that I have received and signed a copy of this authorization.
	Signature Date
If this authorization has been signed by a personal representates, the following must be completed.	esentative of the individual to whom this authorization
I,, am the personal represe	entative of the individual named in this release by virtue of my
status as (state the relationship such as parent, health care represent that I have authority to sign this Authorization.	esentative, guardian, etc.)
Signature	Date