AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Your medical information, including, but not limited to claims information, plan benefit coverage, and appeals, is considered protected health information and may not be disclosed, except under certain circumstances (see Notice of Privacy Practices on the Consolidated Benefits Office site for more information). This form allows you to authorize The Consolidated Benefits Office to disclose your personal health information to those individuals (such as your spouse or relatives) or entities you specify.

MEMBER INFORMATION: Give requested details on the individual whose health information is to be covered by this form.

NAME: _____ DATE OF BIRTH: _____
Last Name, First Name MI

RELATIONSHIP TO EMPLOYEE/RETIREE: ☐ SELF ☐ SPOUSE ☐ CHILD

EMPLOYEE/RETIREE NAME: *(Leave blank if same as Member)* _____
Last Name, First Name MI

EMPLOYEE/RETIREE STATUS: ☐ City ☐ Schools ☐ Retired City ☐ Retired Schools ID #: _____

I voluntarily authorize the City of Virginia Beach and Virginia Beach City Public Schools – Consolidated Benefits Office Staff (hereafter referred to as CBO Staff) to disclose my Protected Health Information as described in this authorization.

1. CBO Staff are authorized to release my protected health information to:
   - ☐ Specific person: _____ Relationship: _____
   - ☐ Specific organization: _____

     Please specify who, with the organization listed above, is covered by this authorization:
     - ☐ All persons with specific organization
     - ☐ Specific class of persons with organization: _____
       Examples: Clinicians, Researchers, Etc.
2. CBO Staff are authorized to disclose the information for the purpose of the following:
   - ☐ At the request of the individual/persons/organization authorized in #1 above or
   - ☐ State specific purpose: _____
3. CBO Staff are authorized to release the information as indicated below (check all that apply) to the individual(s) and/or organization(s) listed above:
   - ☐ Plan benefit coverage and enrollment
   - ☐ Claims information
   - ☐ Authorization and appeals or
   - ☐ State specific description of information: _____
4. CBO Staff are authorized to release the information stated above for the following dates from the date signed by the Member or Legal Representative on this form:
   - ☐ Duration of member's health coverage
   - ☐ Throughout current calendar year
   - ☐ 30 Days
   - ☐ _____ Days (specify)

I understand that I have the right to revoke this voluntary authorization at any time by notifying in writing: **Consolidated Benefits Office, Virginia Beach City Public Schools, 2512 George Mason Drive, Virginia Beach, VA 23456-0038**.
I understand that the revocation is only effective after it is received and logged by Consolidated Benefits Office Staff.
I understand that any use or disclosure made prior to the revocation under this authorization will not be affected by revocation.
I understand that after this information is disclosed, federal law might not protect it and the recipient might redisclose it.
I understand that I am entitled to receive a copy of this authorization.
I understand that this authorization will expire when my employment terminates with the City of Virginia Beach or Virginia Beach City Public Schools or my health care coverage terminates as a retiree or as set forth in number 4 above.

_____ _____
Signature of Member or Legal Representative **Date**

_____ _____ _____
Witness *(Please print: Last Name, First Name)* **Signature of Witness** **Date**

If a Personal Representative executes this form, that Representative warrants that he or she has the authority to sign this form on the basis of: _____