BROOKHAVEN NATIONAL LABORATORY

Brookhaven Science Associates
Comprehensive Welfare Benefits Plan
Authorization For Use And Disclosure Of Private Health Information

Please complete this Authorization form and sign and date where indicated. This Authorization will allow the release of Private Health Information as specified below to the persons or entities specified. This Authorization is not valid without your (or your personal representative's) signature and date.

Participant Information

Name of Participant: _____

Social Security Number: _____

Date of Birth (MM/DD/YYYY): _____

Address (including zip code): _____

_____

Subscriber Information (if different from Participant)

Name of Subscriber _____

Relationship to Participant: _____

Social Security Number: _____

I authorize the following Health Plan(s) to use or disclose my health information in accordance with this Authorization. (check all that apply)

☐ Medical Plan: Plan Name: _____ Acct/Group #: _____

Participant's ID Card Number: _____

☐ Dental Plan: Plan Name: _____ Acct/Group #: _____

Participant's ID Card Number: _____

☐ Health Care Reimbursement Account Acct/Group # 3210488

Indicate Private Health Information to be released.

☐ All of my Health Plan records from _____ through _____
(start date) (end date)

☐ All of my Health Plan records relating to my treatment for _____
(specific diagnosis or condition)

☐ All of my Health Plan records relating to my treatment provided by _____

_____ from _____ through _____
(health care provider's name) (start date) (end date)

☐ Other (please specify) _____

I authorize the persons or entities indicated below to receive the information:

- ☐ Your or the Subscriber's Employer Benefits Office representative
- ☐ Other (please specify) _____

Indicate purpose of this release of information: _____

This Authorization is effective until _____ [expiration date] (if you do not select an expiration date, your Authorization will remain in effect for one year following the termination of your participation in the Brookhaven Science Associates Health Plan) or until revoked by you in writing. You may revoke this Authorization at any time by writing to the Brookhaven Science Associates Privacy Officer at the following address. Revocation forms are available from the Benefits Office. Any revocation will not be effective for any actions already taken.

Brookhaven Science Associates
Brookhaven National Laboratory
Attn: Privacy Officer
Benefits Office, Bldg. 400B
Upton, NY 11973-5000

I hereby authorize the Health Plans to disclose my health information in accordance with this Authorization. I understand that my health information disclosed in reliance on this Authorization may be re-disclosed by the recipients listed above and, as a result, may no longer be protected under applicable health privacy laws or under the Brookhaven Science Associates (BSA) Comprehensive Welfare Benefits Plan's privacy practices. I understand that without my Authorization, the BSA Comprehensive Welfare Benefits Plan may use my information only as described in the BSA Comprehensive Welfare Benefits Plan Notice of Privacy Practices or as permitted under my remaining Authorizations, if any.

This Authorization is made at my request. I understand that treatment, payment, enrollment, or eligibility for Health Plan benefits is not affected by my decision to complete this Authorization form.

I understand that this Authorization is valid until the revocation date indicated above, or until I revoke this Authorization in writing. I understand that I have the right to revoke this Authorization at any time, except to the extent that the Health Plan has already used or disclosed my health information in reliance upon my Authorization.

_____ _____
Signature* **Date**

Relationship if person signing is other than Participant: _____

* If you are signing this Authorization on behalf of another individual, a completed Personal Representative form must be on file with the Health Plan unless you are the minor individual's parent or guardian and you are also a participant in a Health Plan.

Send this completed Authorization form to:

Brookhaven Science Associates
Brookhaven National Laboratory
Attn: Privacy Officer
Benefits Office, Bldg. 185
Upton, NY 11973-5000

This form will not be returned to you. Please make a copy for yourself before sending your Authorization. **If you have any questions about this Authorization form, contact the Benefits Office at (631) 344-2881.**

For internal use only: Date Received: _____ Date Revoked: _____

Approved by: _____