



# The California State University Authorization to Use and/or Disclose Personal Health Plan Information

\_\_\_\_\_

Form Received By                      Date

<b>1. Employee Name</b>	<b>1a. Employee Health Plan ID Number</b>
<b>1b. Employee Date of Birth</b>	<b>1c. Employee Address and Phone Number</b>
<b>2. Name of Person Whose Health Information is the Subject of this Authorization</b>	<b>2a. Relationship to Employee</b> <div style="display: flex; justify-content: space-around; font-size: small;"> <span>Self <input type="checkbox"/></span> <span>Spouse <input type="checkbox"/></span> <span>Child <input type="checkbox"/></span> <span>Other <input type="checkbox"/></span> </div>
<b>3. Your Name</b>	<b>3a. Authority</b> <b>If you are not the person in Box 2, please describe your authority to act on his or her behalf:</b> <hr/> <hr/> <hr/>
<b>4. Mailing Address for Records</b>	<b>4a. City, State, Zip Code</b>

I hereby authorize \_\_\_\_\_ [Insert name of the insurance carrier, HMO, health plan vendor or the CSU Group Health and HCRA Plans who will be disclosing the health information] to use and/or disclose the health information described in Sections A — E below.

**Section A: Health Information to be Used and/or Disclosed.**

Specify the health information to be released and/or used, including (if applicable) the time period(s) to which the information relates. Select only one (1) of the following boxes:

All of my health information, including, but not limited to, dates of service, types of service, treatment charts, x-rays, provider notes or other information, related to the following health condition: \_\_\_\_\_ (please describe).

All of my health information relating to Claim Number \_\_\_\_\_, including, but not limited to, dates of service, types of service, treatment charts, x-rays, provider notes or other information.

Other (please specify). \_\_\_\_\_  
 \_\_\_\_\_

**Section B: Person(s) Authorized to Use and/or Receive Information.**

Specify the persons or class of persons authorized to use and/or receive the health information described in Section A:

\_\_\_\_\_

**Section C: Purposes for Which Information will be Used or Disclosed.**

Specify each purpose for which the health information described in Section A may be used or disclosed. Select all of the applicable boxes below:

- To facilitate the resolution of a claim dispute.
- As part of my application for leave under the Family and Medical Leave Act (FMLA) or state family leave laws.
- For a disability coverage determination.
- At my request.
- Other (please specify) \_\_\_\_\_

**Section D: Expiration of Authorization**

Specify when this Authorization expires. (Provide a date or triggering event related to the use or disclosure of the information.)

- On the following date: \_\_\_\_\_.
- Upon the passage of the following amount of time: \_\_\_\_\_.
- Upon my disenrollment from the CSU Group Health and HCRA Plans.
- Upon my return from FMLA leave.
- Other (please specify) \_\_\_\_\_

**Your rights:**

- You can revoke this Authorization at any time by submitting a written revocation to the campus benefits office.
- A revocation will not apply to information that has already been used or disclosed in reliance on the Authorization.
- Once the information is disclosed pursuant to this Authorization, it may be redisclosed by the recipient and the information will no longer be protected by HIPAA.
- The Plan may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign the Authorization.
- You will be provided with a copy of this Authorization Form, after signing, if the Plan sought the Authorization.

---

**Signature of Participant**

**Date**