Self-Insured Schools of California (SISC)
Authorization Form for Release of Personal Health Information (PHI)

I, ____ , hereby authorize the use or disclosure of the health information as described in this authorization.

1. Specific person/organization/or class of persons authorized to **provide** the information:

   ____

2. Specific person/organization/or class of persons authorized to **receive** and use the information: (*insert name, title, address fax, phone and e-mail if possible)*

   ____

3. Specific **description of the information to be used or disclosed**. (*Include names of individuals to whom the information pertains such as a minor child, description of information and dates, as appropriate*):

   ____

4. **Purpose of the request**: (*Check one*)
   ☐ At the request of the individual signing this form.
   ☐ Other: ____
   (e*.g., to discuss my benefits with _____ and its Claims Administrator so I can understand my benefits.*)

5. **Right to Revoke:** I understand that this authorization is voluntary and that I have the right to revoke this authorization at any time by notifying the **SISC Privacy Officer (in writing) at 2000 "K" Street P.O. Box 1847 - Bakersfield, CA 93303-1847**. I understand that such a revocation is only effective after it is received and logged by the Privacy Officer. I understand that any use or disclosure made prior to the revocation of this authorization will not be affected by a revocation.

6. **I understand that after this information is disclosed, Federal law might not protect it and the recipient might disclose it again**.

7. I understand that I am entitled to receive a copy of this authorization and the information described on this form if I ask for it.

8. I understand that this authorization will expire as indicated below:
   ☐ One year from the date of this authorization.
   ☐ On the following date: ______________________________, 20___.

9. The Plan will not condition treatment, payment, enrollment or eligibility for benefits on receipt of an authorization.

10. If this authorization is **for marketing purposes**, this Plan is not receiving financial remuneration (payment) from the third party whose service or item is being marketed. If the authorization is **for the sale of protected health information**, the disclosure will not result in remuneration (payment) to the Plan.

____ ______________________

Signature of Individual Date

or

____ ______________________

Signature of Personal Representative Date

If a Personal Representative executes this form, that Representative warrants that he or she has authority to sign the authorization form on the basis of: ☐ a signed Personal Representative Form; or ☐ Other _________________________

This authorization reflects the requirements of 45 CFR § 164.508 (8-14-02) and updated for HIPAA Omnibus (9-23-13).