ALAMEDA COUNTY EMPLOYEES' RETIREMENT ASSOCIATION

475 – 14TH STREET, SUITE 1000, OAKLAND, CA 94612 1-800-838-1932 510-628-3000 FAX: 510-268-9574

HIPAA AUTHORIZATION FORM

Disclaimer: This document is provided solely for reference purposes. Covered Entities under HIPAA are advised to refer to their institutions Privacy Policy for specific requirements for the HIPAA Authorization.

I, _____, give permission to Alameda County Employees' Retirement Association to:

☐ Use the following protected health information, and/or

☐ Disclose the following protected health information to (check all that apply):

- ☐ ACERA
- ☐ PacifiCare/UnitedHealthcare
- ☐ Kaiser
- ☐ Blue Cross
- ☐ Delta Dental
- ☐ Vision Service Plan (VSP)
- ☐ All of the above

Information to be disclosed (check all that apply):

- ☐ Medical Plan Information
- ☐ Dental Plan Information
- ☐ Vision Plan Information
- ☐ Other:

_____

_____

_____

This authorization expires after one year or until current issue is resolved.

If the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be disclosed to other individuals or institutions and no longer protected by these regulations.

You may refuse to sign this authorization. Your refusal to sign will **not** affect your ability to obtain treatment or payment or your eligibility for benefits.

You may inspect or copy the protected health information to be used or disclosed under this authorization. For protected health information created as part of a clinical trial, your right to access is suspended until the clinical trial is completed.

THE RESERVE SIDE OF THIS FORM MUST BE SIGNED

05/18/07

For Office Use Only*
Input by: _____ Date: _____
Verified by: _____ Date: _____

Finally, you may revoke this authorization in writing at any time by sending written notification to ACERA at 475 14th Street, Suite 1000, Oakland, CA 94612. Your notice will not apply to actions taken by the requesting person/entity prior to the date they receive your written request to revoke authorization.

Signature of Participant or Personal Representative

Date

Printed Name of Participant or Personal Representative