County of Onondaga
Personnel Department
John H. Mulroy Civic Center, 11th Floor
421 Montgomery Street, Syracuse, NY 13202
Phone: 315.435.3537 Fax: 315.435.8272
www.ongov.net

J. Ryan McMahon, II
County Executive

Carlton Hummel
Commissioner

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

1. Employee Information

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Birth Date: _____

2. Purpose of this Authorization: Please note, that by signing this form, you will authorize Onondaga County Employee Benefits to disclose your protected health information for the following purposes.

____ Any Purpose

____ Any Purpose Excluding Mental Health or HIV

____ Specific Medical Condition _____

3. Protected Health Information to Be Disclosed: Please indicate the specific protected health information you authorize us to disclose. Please check all that apply:

____ Claim Information (e.g. status, type of service, diagnosis, provider, dates of service, etc.)

____ Membership Information (e.g. coverage information, eligibility, address, dates of birth, etc.)
____ Benefit Information (e.g. benefits available, benefits used, contract limits, etc.)
____ Medical Records (e.g. physician or hospital records, case management, etc.)
____ Substance Use Disorder Treatment Records (subject to 42 CFR Part 2 protections)

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4. **Entity Authorized to Receive: Please indicate the person's name and address to whom you are authorizing Onondaga County Employee Benefits to disclose the protected health information described above:**

Name: _____
Address: _____
City: _____ State: _____ Zip: _____

5. **The Onondaga County Employee Benefits Division is required by law to protect your health information. By signing this document, you authorize the Onondaga County Employee Benefits Division to use and/or disclose (release) your health information. Those persons who receive your health information may not be required by Federal privacy laws (such as the Privacy Rule) to protect it and may share your information with others without your permission, if permitted by laws governing them.**

6. **Signature:**

I, (*please print*) _____, have had full opportunity to read and consider the contents of this authorization. I understand that, by signing this form, I am confirming my authorization that the Onondaga County Employee Benefits Division may disclose to the person named in this form the protected health information described in this form. I understand that this authorization is only valid while enrolled in my current group.

I understand that I may revoke this authorization at any time by giving written notice of revocation to the office listed below. Revocation of this authorization will not affect any action taken in reliance on this authorization before written notice of revocation is received.

Signature: _____ Date: _____

Please complete and return this form to:
Onondaga County Employee Benefits Division
421 Montgomery Street 11th Floor
Syracuse, NY 13202