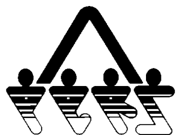

PARTICIPANT'S AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM
SFN 58770 (Rev. 03-2010)

NDPERS • PO Box 1657 • Bismarck, • North Dakota 58502-1657
(701) 328- 3900 • 1-800-803-7377
Fax 701-328-3920

PART A MEMBER INFORMATION	
Name (Last, First, Middle)	NDPERS Member ID
Last Four Digits of Social Security Number	Date of Birth
Health Plan ID Number	

PART B MEMBER AUTHORIZATION & ACKNOWLEDGEMENT

I ___________________________________ authorize NDPERS administrative staff to disclose the following protected health information to *(Name of entity or class of persons to receive information):*

____

____

____

Description of the information to be used or disclosed *(Specifically and meaningfully describe the protected health information to be used or disclosed such as date of service, type of service, level of detail to be released, origin of information, etc.)*

____

____

____

This protected health information is being used or disclosed for the following purposes: *(List specific purposes here. "At the request of the individual" is acceptable if the patient makes the request, and the patient does not want to state a specific purpose.)*

____

____

____

This authorization shall be in force and effect until: *(Specify (1) date or (2) event that relates to the patient or the purpose of the use or disclosure at which time this authorization to use or disclose this protected health information expires.)*

☐ Until this Date *(mm/dd/yyyy)* _________________ [up to 3 yrs; 23-12-14(2)(a)]

☐ None (Acceptable for authorization for research purposes when information goes into a long-term or permanent database, e.g., a cancer registry.)

I understand that I have the right to revoke this authorization, in writing, at any time by sending a written notification to NDPERS at 400 East Broadway, Bismarck, ND 58502, or by sending an e-mail to NDPERS at ndpers-info@nd.gov.

I understand that a revocation is not effective to the extent that NDPERS administrative staff has relied on the use or disclosure of the protected health information.

I understand that information disclosed under this authorization may be further disclosed by the recipient and may no longer be protected by federal or state law.

NDPERS administrative staff will not condition my treatment, payment, or enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure.

____
Signature of Patient or Personal Representative

____
Date

______________________________________ ______________________________________
Print Name of Patient Print Name of Personal Representative

Print address, phone number, and email of Personal Representative (*if applicable)*

Address ______________________________________
____
Phone No. ______________________________________
E-mail ______________________________________

____
Description of Personal Representative's Authority *(Parent, Guardian, etc.)*

You are not required to sign this authorization form. If you do sign this form, you have a right to receive a copy of the completed authorization.

☐ **Please provide me with a copy of this authorization form.**