



Authorization for Use or Disclosure of Health Information

As a participant in a plan subject to the provisions of COBRA, USERRA, Cal-COBRA, or any other state continuation law, certain data relating to your participation is considered to be Protected Health Information (PHI) pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This form provides authorization for the disclosure and/or use of individually identifiable health information, as shown below, consistent with State and Federal law concerning HIPAA Privacy and State Privacy Laws. This authorization will remain in effect until the end of your eligibility for plan continuation under the provisions of COBRA, USERRA, Cal-COBRA, or any other state continuation law.

Employee/Participant Name: _____ Social Security Number: ____ - ____ - ____

I authorize release of information regarding my participation in a plan, as stated above, to COBRA Plus Administrators, Inc. for the administration of plan continuation. The information that may be released will be limited to coverage and payment information unless I provide authorization for release of PHI to COBRA Plus Administrators, Inc. as indicated below. Diagnosis of participant or eligible dependents will not be disclosed except as required by law. I further authorize disclosure of information to those acting in my behalf as shown:

Family Members/Other: Name	Relationship	Last 4 of Social Sec. No. (To Identify Eligibility)	Do Not Disclose The Following:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

You are authorized to disclose the following information to COBRA Plus Administrators, Inc. (i.e. dates of service, total charges, provider of service, account balance, denial reason, or claim status): _____

Expiration of Authorization

This authorization will remain in effect until:

- End of continuation coverage period
- Termination Date: _____

Signature

I hereby authorize the use and/or disclosure of Protected Health Information as noted above to those individuals identified. I further understand the following:

- I may revoke this authorization at any time. It must be in writing, signed by me and forwarded to the address below and will be effective upon receipt.
- I can refuse to sign this authorization; however, the individuals designated above will not have authorization for information without it.
- I have the right to receive a copy of this authorization.
- I have the right to inspect information that has been disclosed.
- Information will only be disclosed to those identified above.
- Once information is disclosed, it may no longer be protected under HIPAA; however, California and several other states enacted privacy laws prohibiting subsequent disclosure of health information.

Participant Printed Name: _____ Signature: _____ Date: _____