UFT/RTC SUPPLEMENTAL HEALTH INSURANCE PROGRAM ("SHIP")

AUTHORIZATION FORM

I, YOUR NAME (please print name) authorize the UFT/RTC Supplemental Health Insurance Program ("Ship"), to use and/or disclose the following protected health information (specify the information to be disclosed, including but not limited to, date of service, type of service provided, specific claim, etc.):

MEDICAL CLAIMS AND INFORMATION

I authorize the following person(s) and/or organization(s) to receive my protected health information from the Fund:

YOU NAME PERSON(S) YOU WISH TO DESIGNATE

I authorize my protected health information to be used and/or disclosed for the following specific purposes:

MEDICAL CLAIMS AND INFORMATION

Right to Revoke. I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the **Privacy Officer for the Fund at 52 Broadway, 17th Floor, New York, New York 10004**. I am aware that my revocation will not be effective as to uses and/or disclosures of my health information that the Fund has already made in reliance upon this authorization.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal law.

I understand that the Fund may not condition treatment, payment, enrollment or eligibility for health care benefits on my decision to sign this authorization.

Expiration of Authorization. This authorization will expire (choose and complete one):

☐ On _____/_____/_____.
MM / DD / YR

☒ Upon the occurrence of the following event(s) related to my health care or to the purpose(s) for which I have authorized the use and/or disclosure of my health information described above:

__X__ **When I am no longer a covered member under SHIP**

_____ **When I am no longer a covered dependent under SHIP**

_____ **Other (please describe the event below:)**

SIGN AND RETURN TO SHIP OFFICE _____/_____/_____
Member Signature or Personal Representative Date

If signed by a personal representative, complete the following:

Relationship to participant or nature of authority (e.g., health care power of attorney, guardian, other statutory authorization): _____

***Personal Representative is requested to provide documentation as proof of authority**