58769

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM

SFN 58769 (Rev. 01-2022)

Clear Form

NDPERS • PO Box 1657 • Bismarck • ND • 58502-1657
(701) 328-3900 • (800) 803-7377 • Fax (701) 328-3920 • ndpers-info@nd.gov

PART A MEMBER INFORMATION

Member Name (Last, First, Middle)	NDPERS Member ID
Last Four Digits of Social Security Number	Date of Birth (mm/dd/yyyy)

PART B MEMBER AUTHORIZATION AND ACKNOWLEDGEMENT

Name *(if different from above)*

I, as named above, authorize NDPERS administrative staff to *(Check all that apply)*

☐ use the following protected health information, and/or

☐ 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)]

☐ End of the research study *(Acceptable for authorization for research purposes.)*

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

Member Name (Last, First, Middle)	NDPERS Member ID

I understand that I have the right to revoke this authorization, in writing, at any time by sending a written notification to NDPERS at PO Box 1657, Bismarck, ND 58502-1657, 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 (Electronic signatures will not be accepted)	Date

Print Name of Patient	Print Name of Personal Representative

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

Address	Phone number	E-mail Address

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.**