

**Self-Insured Schools of California (SISC)  
Authorization Form for Release of Personal Health Information (PHI)**

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I, \_\_\_\_\_, hereby authorize the use or disclosure of the health information as described in this authorization.

1. Specific person/organization/or class of persons authorized to **provide** the information:  
\_\_\_\_\_
2. Specific person/organization/or class of persons authorized to **receive** and use the information: *(insert name, title, address fax, phone and e-mail if possible)*  
\_\_\_\_\_
3. Specific **description of the information to be used or disclosed.** *(Include names of individuals to whom the information pertains such as a minor child, description of information and dates, as appropriate):*  
\_\_\_\_\_
4. **Purpose of the request:** *(Check one)*  
 At the request of the individual signing this form.  
 Other: \_\_\_\_\_  
*(e.g., to discuss my benefits with \_\_\_\_\_ and its Claims Administrator so I can understand my benefits.)*
5. **Right to Revoke:** I understand that this authorization is voluntary and that I have the right to revoke this authorization at any time by notifying the **SISC Privacy Officer (in writing) at 2000 "K" Street P.O. Box 1847 - Bakersfield, CA 93303-1847.** I understand that such a revocation is only effective after it is received and logged by the Privacy Officer. I understand that any use or disclosure made prior to the revocation of this authorization will not be affected by a revocation.
6. **I understand that after this information is disclosed, Federal law might not protect it and the recipient might disclose it again.**
7. I understand that I am entitled to receive a copy of this authorization and the information described on this form if I ask for it.
8. I understand that this authorization will expire as indicated below:  
 One year from the date of this authorization.  
 On the following date: \_\_\_\_\_, 20\_\_\_\_.
9. The Plan will not condition treatment, payment, enrollment or eligibility for benefits on receipt of an authorization.
10. If this authorization is **for marketing purposes**, this Plan is not receiving financial remuneration (payment) from the third party whose service or item is being marketed. If the authorization is **for the sale of protected health information**, the disclosure will not result in remuneration (payment) to the Plan.

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Signature of Individual

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Date

or

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Signature of Personal Representative

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Date

If a Personal Representative executes this form, that Representative warrants that he or she has authority to sign the authorization form on the basis of:  a signed Personal Representative Form; or  Other \_\_\_\_\_

*This authorization reflects the requirements of 45 CFR § 164.508 (8-14-02) and updated for HIPAA Omnibus (9-23-13).*