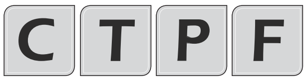


HIPAA Authorized Representative Designation

425 S. Financial Place, Suite 1400 | Chicago, IL 60605-1000 | 312.641.4464 | *Fax* 312.641.7185 | www.ctpf.org

FORM 345 (REV. 7/2022)

AUTHORIZED REPRESENTATIVE

CTPF may use protected health information (PHI) as provided in the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Completing and signing this form gives the Chicago Teachers' Pension Fund permission to discuss and/or release PHI to a person you designate as an Authorized Representative. This authorization is not a power of attorney and does not allow your Authorized Representative to make any of your treatment or direct care decisions.

SECTION 1: PATIENT INFORMATION AND AUTHORIZED USE AND/OR DISCLOSURE

By completing this form I understand and agree that the Chicago Teachers' Pension Fund may release my protected health information (PHI), including claim information, to my Authorized Representative named in Section 2 below. I understand that once this information is released to my Authorized Representative it is no longer governed by HIPAA or state privacy laws.

Patient Name: First	M.I.	Last	**Member ID/Last 4 Digits of SSN:**

Date of birth:	**Mailing address:** Street	Apt. or Unit No	City	State	Zip

Email Address:	**Telephone number:** *(with area code)*

SECTION 2: AUTHORIZED REPRESENTATIVE INFORMATION

I authorize the Chicago Teachers' Pension Fund to discuss and give out my PHI to the person(s) named below. I understand that it is for the purpose of helping me to receive my health plan benefits or for the payment of my heath plan benefits. I understand and agree that my authorization is voluntary.

Authorized Representative #1:

Name: First	M.I.	Last	**Telephone number:**

Mailing address: Street	Apt. or Unit No	City	State	Zip

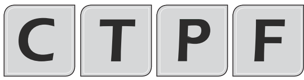
Email Address:	**Relationship to you:**

Authorized Representative #2:

Name: First	M.I.	Last	**Telephone number:**

Mailing address: Street	Apt. or Unit No	City	State	Zip

Email Address:	**Relationship to you:**



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SECTION 3: LIMITATIONS ON DISCLOSURE

I understand that by leaving this section blank, I am allowing all of my PHI to be known by my Authorized Representative. Otherwise, please list limitations on disclosures here:

SECTION 4: CANCELLING THIS AGREEMENT

This authorization will expire on: *(insert date)**

____________/_______________/___________

Month **Date** **Year**

*If no date is provided, this authorization will remain in effect until I cancel this authorization in writing and send such notice to the address below.

I understand that if CTPF has released PHI before a cancellation notice is received, my notice cannot cancel any action already taken.

SECTION 5: SIGNATURE OF INDIVIDUAL OR INDIVIDUAL'S LEGAL REPRESENTATIVE

I have read and understand the content of this Authorized Representative Form. This authorization correctly describes my request to CTPF. I understand that by signing this form, I am giving permission for CTPF to use and/or give out my PHI to the person(s) named in Section 2. I understand that my Authorized Representative may further disclose my PHI without my consent.

Signature	**Date**
Witness	**Date**

(A witness is only needed if the Individual is unable to sign or the witness is an interpreter).

If this Authorized Representative Form is signed by your legal representative on your behalf, please attach the documentation of legal representative designation and complete the following:

Legal Representative's Name: First	M.I.	Last			**Telephone number:**
Mailing address: Street		Apt. or Unit No	City	State	Zip
Relationship to you:					

Please keep a copy of this form for your records. You also have the right to receive a copy of this Authorized Representative Form.

PLEASE RETURN THIS SIGNED AUTHORIZATION FORM TO:
Chicago Teachers' Pension Fund
425 S. Financial, Suite 1400
Chicago, Illinois 60605-1000

Fax: 312-641-7185

You may also email a pdf to memberservices@ctpf.org.