CTPF
Chicago Teachers' Pension Fund

HIPAA Authorized Representative Designation

FORM 345
Updated 09/2015

203 North LaSalle Street, suite 2600 | Chicago, Illinois 60601-1231 | Phone: 312 641 4464 | Fax: 312 641 7185 | www.ctpf.org

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	middle initial	last	**Last 4 Digits SSN**
Mailing address	street			apt. or unit no.

city	state	zip	**Date of birth**	**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	middle initial	last	**Telephone number**
Mailing address	street			apt. or unit no.

city	state	zip	**Relationship to you**

Authorized Representative #2:

Name	first	middle initial	last	**Telephone number**
Mailing address	street			apt. or unit no.

city	state	zip	**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	middle initial	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
203 North LaSalle Street, suite 2600
Chicago, Illinois 60601-1231

Fax: 312-641-7185

You may also e-mail a pdf to **memberservices@ctpf.org**.