Administrative Services Only, Inc. Authorization Form

Health Insurance Portability and Accountability Act (HIPAA)

303 Merrick Road Lynbrook, NY 11563

Tel: (516) 396-5500 / (800) 537-1238 (outside NY) / Fax: (516) 396-5593

I. Participant information (please print)

LAST NAME	FIRST NAME	SOCIAL SECURITY #:	
ADDRESS	CITY	STATE	ZIP
DATE OF BIRTH	HOME TELEPHONE	WORK TELEPHONE	
AGENCY NAME			

II. Specific person/organization (or class of persons) authorized to receive and use the information

NAME	RELATION TO PARTICIPANT	NAME	RELATION TO PARTICIPANT
1.		2.	
3.		4.	
5.		6.	

III. Specific description of the information: (medical examination reports, etc)

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IV. Right to revoke

I understand that I have the right to revoke this authorization at any time by notifying ASO in writing at 303 Merrick Rd., 3rd Floor, Lynbrook, NY 11563. I understand that the revocation is only effective after it is received and logged by MBF. I understand that any use or disclosure made prior to the revocation under this authorization will not be affected by a revocation. I understand that after this information is disclosed, federal law might not protect it and the recipient might redisclose it. I understand that I am entitled to receive a copy of this authorization. I understand that this authorization will expire when my employment with ASO terminates.

Signature _____ Date _____

If a Personal Representative executes this form, that Representative warrants that he or she has authority to sign this form on the basis of: _____