# SUFFOLK COUNTY MUNICIPAL EMPLOYEES BENEFIT FUND



30 ORVILLE DRIVE
SUITE D
BOHEMIA, NY 11716-2513

PHONE (631) 319-4099
FAX (631) 218-7970
www.scmebf.org

SCOTT MIRABELLA, ADMINISTRATOR



## AUTHORIZATION FOR RELEASE OF INFORMATION

I _____ hereby authorize the Suffolk County Municipal Employees Benefit Fund (the Fund) to disclose my identifiable benefits information as described in this authorization to the individuals listed below:

| Name | Relationship (Spouse, Parent, etc.) |
|---|---|
| 1. | |
| 2. | |
| 3. | |
| 4. | |
| 5. | |

I authorize the disclosure of treatment and payment information for the following benefits (check all that apply):

☐ Dental ☐ Vision ☐ Prescription ☐ Hearing

With the exception of the following types of services: _____

_____

_____

I understand that I am entitled to receive a copy of this authorization.

I understand that after information is disclosed to the above individuals, federal privacy regulations might not protect that information and the recipient might disclose it to others.

I understand that I have the right to revoke this authorization for any of the above individuals at any time by notifying the Fund in writing at 30 Orville Drive, Suite D, Bohemia, NY 11716-2513. I understand that the revocation is only effective after it is received in writing and logged by the Fund.

I understand that this authorization is valid until such time as I revoke it in writing, until my death, or, if my employment with Suffolk County terminates, for as long as the Fund retains my records.

**BF#:** _____ *or* **PIN:** _____

**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: _____