BOSTON UNIVERSITY

# AUTHORIZATION FOR RELEASE OF INFORMATION

## I. INFORMATION ABOUT THE USE OR DISCLOSURE

I hereby authorize the use or disclosure of my individually identifiable information as described below. I understand that this authorization is voluntary and that I may revoke it at any time by submitting my revocation in writing to the entity providing the information.

Participant name: SSN Number:

Persons authorized to receive the information:

Relationship to the participant, including authority for status as representative:

☐ I authorize any and all information shared with the above named persons, with the following exception(s):

## II. IMPORTANT INFORMATION ABOUT YOUR RIGHTS

I have read and understand the following statements about my rights:

• I may revoke this authorization at any time by notifying the providing organization in writing, but the revocation will not have any affect on any actions the entity took before it received the revocation.

• I may see and copy the information described on this form if I ask for it.

• I am not required to sign this form to receive my health care benefits (enrollment, treatment or payment).

• The information that is used or disclosed pursuant to this authorization may be redisclosed by the receiving entity. I have the right to seek assurances from the above-named persons/organizations authorized to receive the information that they will not redisclose the information to any other party without my further authorization.

## III. SIGNATURE OF PARTICIPANT

Signature of participant Date

**(FORM MUST BE COMPLETED BEFORE SIGNING.)**

Please fax this completed form to P&A via toll-free number: [877] 855-7105
or mail to: Attn - Flex Department, 17 Court Street, Suite 500, Buffalo, NY 14202

P&A GROUP