

4. Right to Revoke. I understand that I have the right to revoke this authorization at any time and that my revocation of this authorization must be in writing. I understand that any revocation must include my name, address, telephone number, the date of this authorization, and my signature and that I should send it to the State Health Benefits Program — HIPAA Privacy Officer, State of New Jersey, Department of the Treasury, Division of Pensions and Benefits, PO Box 295, Trenton, NJ 08625-0295. I am aware that my revocation will not be effective as to uses and/or disclosures of my health information that have already been made in reliance upon this authorization.

5. Expiration of Authorization. This authorization will expire (check one and complete):

On: / /
MM / DD / YYYY

Upon the occurrence of the following event(s) or until I revoke this authorization:

MEMBER'S SIGNATURE

I have had an opportunity to review and understand the contents of this form. By signing this form, I am confirming that it accurately reflects my wishes.

_____ **Date:** / /
MEMBER'S SIGNATURE MM / DD / YYYY

If signed by a personal representative, complete the following:

Name of Personal Representative: _____

Relationship to Member or Nature of Authority: _____
(e.g., health care power of attorney, guardian, other legal authorization — **A copy of documentation must be attached.**):

Address: _____

Daytime Telephone Number: () _____ **E-mail:** _____
AREA CODE

_____ **Date:** / /
SIGNATURE OF PERSONAL REPRESENTATIVE MM / DD / YYYY