



State of New Jersey • Department of the Treasury

DIVISION OF PENSIONS & BENEFITS

P.O. Box 295, Trenton, NJ 08625-0295

MEMBER AUTHORIZATION FORM

FOR USE AND DISCLOSURE OF PROTECTED AND PRIVATE INFORMATION

PART 1 — MEMBER'S INFORMATION

| Member's Name | | First | MI |
|--|---|---|--|
| Address | City | State | e Zip |
| Phone Number | Email | | |
| Member's Social Security Nu | mber | Date of Birth _ | |
| & Benefits (NJDPB) to releat that health information from | below and signing this form, I ase and/or disclose my protecte the NJDPB can be provided to r of the Administrative Simplificat A) of 1996. | d and private information ne, but is otherwise Prote | n. Further, I understand ected Health Information |
| I submit this form voluntarily described below. | to document my wishes regard | ling the use and/or disclo | sure of the information |
| The following is a specific de | scription of the information I auth | orize be used and/or discl | osed: |
| I authorize my protected and | private information to be used ar | nd/or disclosed for the follo | owing specific purposes: |
| | son(s) or organizations to receiv the purposes listed above. I und al privacy standards. | | |
| | | | |
| | | | |

Expiration of Authorization. Upon release of the information described above, this authorization request will expire. Any future requests to release and/or disclose protected and private information will require a new *Member Authorization Form*.

MEMBER'S SIGNATURE

I have had an opportunity to review and understand the contents of this form. I have signed this form voluntarily and confirm that it accurately reflects my wishes regarding the use and/or disclosure of this information. I understand that the requested documents will be mailed via the United States Postal Service (USPS) First-Class mail and will not require a signature.

| | | | / / |
|---|--|-----------------------------|------------|
| Λ | Member's Signature | | Date |
| If signed by a personal representati | ve, complete the following: | | |
| Name of personal representative _ | | | |
| Relationship to member or nature of | f authority | | |
| (e.g., health care power of attorney, guardia | nn, other legal authorization — A copy of o | documentation must be attac | ched.) |
| Address | | | |
| Street | City | State | Zip |
| | | | 1 1 |
| Signature of Personal Representative | | | // Date |
| Phone Number | | Email | |
| | | | |
| Return completed form to: | New Jersey Division of Pens Office of Client Services | sions & Benefits | |
| | P.O. Box 295 | | |

Trenton, NJ 08625-0295