



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 \_\_\_\_\_  
*Last First MI*

Address \_\_\_\_\_  
*Street City State Zip*

Phone Number \_\_\_\_\_ Email \_\_\_\_\_

Member's Social Security Number \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

By providing the information below and signing this form, I authorize the New Jersey Division of Pensions & Benefits (NJDPB) to release and/or disclose my protected and private information. Further, I understand that health information from the NJDPB can be provided to me, but is otherwise Protected Health Information pursuant to the Privacy Rule of the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

I submit this form voluntarily to document my wishes regarding the use and/or disclosure of the information described below.

The following is a specific description of the information I authorize be used and/or disclosed:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I authorize my protected and private information to be used and/or disclosed for the following specific purposes:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I authorize the following person(s) or organizations to receive my information from the NJDPB and to use or disclose such information for the purposes listed above. I understand that some or all of the information may no longer be protected by federal 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*.

