CENTRAL PENNSYLVANIA TEAMSTERS HEALTH AND WELFARE FUND

AUTHORIZATION FORM

By signing and submitting this form, I am authorizing the Central Pennsylvania Teamsters Health and Welfare Fund to disclose my protected health information ("PHI") to the person identified below. This includes PHI in the Fund files about me, the medical treatment I have received and the payment status of claims for medical treatment. I understand that this authorization is voluntary and that I can revoke it at any time by informing the Fund in writing that I am revoking this authorization.

_____ _____
Name of Participant or Dependent (Print or Type) Date of Birth

Participant ID #_____

_____ _____
Signature of Participant or Dependent Date

I authorize the Central Pennsylvania Teamsters Health and Welfare Fund to disclose the above individual's protected health information to:

_____
Name of person/organization

_____
Address and Telephone Number

_____
Relationship of Authorized Individual to Participant or Dependent

I authorize the Fund to disclose the information described below to my authorized representative.

__ All claims and appeals __ Billing/enrollment

__ Specific Claims: (specify date(s) of service, claim number(s), etc.)

__ Other: (please specify)
_____

Purpose of Disclosure: (Please describe the reason this information is needed or check the following:)

__ This information is being disclosed at the request of the participant.

_____
Reason

- OVER -

The Fund needs your specific authorization to release protected health information pertaining to the items listed below. An authorization for psychotherapy notes cannot be used for any other type of information. By initialing, I authorize release of the information pertinent to my case:

Mental Health	___ (Initials)	Substance Abuse	___ (Initials)
HIV/AIDS	___ (Initials)	Psychotherapy Notes	___ (Initials)

Expiration: This authorization will expire on: (One of the following expiration boxes must be checked).

__ This specific date* ___/___/____ __ One year
__ Termination of coverage __ Six months after termination of coverage

*(Please note that even if a specific date is given, this authorization will expire no later than six months after termination of enrollment with Central Pennsylvania Teamsters Health and Welfare Fund)

Right to Terminate or Revoke Authorization
You may revoke or terminate this authorization at any time by submitting a written revocation to the Central Pennsylvania Teamsters Health and Welfare Fund to Cherie Freeman, Health and Welfare Benefits Manger, to terminate this authorization.

Potential for Redisclosure
I understand the nature of this release. I also understand that if the person or organization I authorize to receive the information described above is not subject to federal health information privacy laws, they may further disclose the protected health information and it may no longer be protected by federal health information privacy laws. I understand that my authorizing the use and disclosure of my information is not a condition of enrollment in this health plan, eligibility for benefits, or payment of claims.

_____ _____
Print Name Signature

_____
Date

1/1/2017