Teamsters Security Fund for Southern Nevada Local 14

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

If you complete and sign this Authorization for Use and Disclosure, you give permission to the specified individuals or entities listed herein to use and disclose medical information that is detailed enough to identify you. Such information is called Protected Health Information ("PHI"). For more information regarding PHI and your related rights, please refer to the Teamsters Security Fund for Southern Nevada Local 14 Notice of Privacy Practices.

Participant Information Policy Holder's ID # or last four of Social: _____

Name: _____ Date of Birth: _____
Address: _____ Phone: _____

Describe the PHI you are authorizing the Plan to use and disclose.

_____

Name or otherwise identify the individuals, entities, or types of individuals or entities you authorize to use or disclose your PHI described above. Please provide any names of specific individuals or entities and provide contact information.

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Name or otherwise identify the individuals or entities you authorize to receive the PHI you described above. Please provide any names of specific individuals or entities and provide contact information (address and telephone).

_____
_____

Describe the purpose for which you authorize use and disclosure of the PHI you described above, or if you prefer, simply state that this authorization to use and disclose your PHI is made "at my request."

_____
_____

State the date this Authorization expires, or if you do not know the specific date, describe the circumstances that will trigger the expiration of this Authorization. You may also indicate "none."

_____
_____

Signature: _____ Print Name: _____ Date: _____

If the person signing is a Personal Representative, describe how the person signing became a Personal Representative of the individual and attach appropriate documentation. _____

NOTICE: You have a right to revoke this Authorization before it expires by notifying the Plan's Administrator in writing, unless the Plan has already used or disclosed information based on your Authorization or if your coverage required information obtained based on the Authorization. The Plan may not condition treatment, payment, enrollment or eligibility for benefits on whether you sign this Authorization except if this Authorization is for the Plan's eligibility or enrollment determinations or for underwriting or risk rating determination (unless this Authorization is for use or disclosure of psychotherapy notes). It is possible that information disclosed pursuant to this Authorization may be disclosed by others who receive it and no longer protected by applicable privacy laws. A COPY OF THIS AUTHORIZATION MUST BE GIVEN TO THE INDIVIDUAL SIGNING IT.

Please return to the address below