TEAMSTERS BENEFIT TRUST
AUTHORIZATION TO OBTAIN AND DISCLOSE PERSONAL HEALTH INFORMATION

Participant Name: _____ Social Security or ID #: _____ Birth Date: _____
Address:_____
Home Telephone Number: _____
Work Telephone Number: _____

The undersigned hereby authorizes **TEAMSTERS BENEFIT TRUST** to use and/or disclose my personal health information to _____for the following purpose(s) only:
(name of person or organization)

_____

_____

The terms and conditions of this authorization are as follows:

1. The health information covered by this authorization is restricted to such information that is minimally necessary to accomplish the specific purpose(s) stated above.

2. I understand that the only persons and/or organizations that are required to comply with federal privacy rules are health care providers, health plans and health care clearinghouses. If the purpose of this authorization requires disclosure of my health information to others, federal privacy rules will not apply to those persons.

3. No one who I am authorizing to obtain, use or disclose my health information may condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization, except when necessary to make a ruling on my eligibility (and psychotherapy notes are not requested), or when necessary to make a claim payment determination (and psychotherapy notes are not requested).

4. This authorization may be revoked in writing at any time. Upon my request, a copy of a revocation form will be supplied to me by Privacy Officer, Teamsters Benefit Trust, P.O. Box 5820, Fremont, CA 94537-5820 Tel. 510-796-4676. I further understand that my revocation will not be effective as to the uses of my health information that have already been made in reliance upon this authorization.

5. I or my designees have the right to inspect or copy the health information to which this authorization applies.

6. This authorization will expire (check one of the boxes below, if none is checked it will be effective indefinitely).

□ when the purpose of the authorization has been completed, but no longer than 24 months after this authorization is signed.

□ on _____
month/day/year

I acknowledge that I have read and understand the contents of this form; that I have been given a copy of this authorization; and that I am signing this authorization voluntarily.

_____
(print name)

_____ _____
(signature) (Date Signed)

If signed by Participant's personal representative, please complete the following:

Relationship to participant or nature of authority (*e.g.*, health care power of attorney, guardian, other statutory authorization):
_____

Address: _____

Telephone number: _____