

TEAMSTERS HEALTH & WELFARE FUND
Of Philadelphia and Vicinity

Authorization to Disclose Protected Health Information

[A separate authorization must be used if the authorization is for psychotherapy notes.]

Participant Name: _____

Birth Date: ____/____/____
MM / DD / YR

Address: _____

Home Telephone Number: _____
Work Telephone Number: _____

E-mail: _____

Participant Identification Number and/or Social Security Number: _____

By signing this authorization form I authorize the person(s) and/or organization(s) described below to use and/or disclose my health information (information that constitutes protected health information as defined in the Privacy Rule of the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996) in the manner described below. I understand that I am under no obligation to sign this form. I have signed this form voluntarily to document my wishes regarding the use and/or disclosure of the health information described below in Section 1 of this form.

1. Description of Health Information I Authorize to be Used or Disclosed. The following is a specific description of the health information I authorize be used and/or disclosed: (Specify and provide a meaningful description.)

2. I authorize the Teamsters Health & Welfare Fund of Philadelphia and Vicinity ("Health & Welfare Fund"), to use and/or disclose the health information described above in Section 1 of this form.

3. Persons/Organizations Authorized to Receive and/or Use My Health Information. I authorize the following person(s) and/or organization(s) (or classes of persons and/or organizations) to receive my health information from the person(s) and/or organization(s) described in Section 2 above and to use or disclose such information for the purposes listed below in Section 4 of this form. I understand that if the person(s) and/or organization(s) listed below are not health care providers, health plans or health care clearinghouses subject to federal privacy standards, the health information disclosed pursuant to this authorization may no longer be protected by the federal privacy standards and such person(s) and/or organization(s) may redisclose my health information without obtaining my authorization.

4. Description of Each Purpose for the Requested Use and/or Disclosure. I authorize my health information to be used and/or disclosed for the following specific purposes:

