Teamsters Industrial Employees Welfare Fund
Authorization for Disclosure of Protected Health Information

I,_____, authorize the disclosure of my protected health information[1] as described herein. I understand that this authorization is voluntary and made to confirm my direction. I understand that, if the person(s) or organization(s) that I authorize to receive my protected health information are not subject to federal and state health information privacy laws[2], subsequent disclosure by such person(s) or organization(s) may not be protected by those laws.

1. I AUTHORIZE and DIRECT the following person(s) and/or organization(s) to disclose my protected health information (as specified below):

Organization: **Teamsters Industrial Employees Welfare Fund**

Address: **707 Summit Avenue, Union City, New Jersey, 07087**

2. I authorize the following person(s) to receive my protected health information, as disclosed by the organization above.

Name:

Address:

Name:

Address:

3. (a) Specific description of the protected health information that I authorize for disclosure (authorization to disclose psychotherapy notes must be separate):

Any and all information maintained by the Fund office in connection with treatment and/or services covered by the Welfare Fund.

(b) As evidenced by my initials hereto: _____ I hereby specifically authorize and direct that this **Authorization for Disclosure of Protected Health Information** is to include mental health records, psychotherapy records, substance abuse records.

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[1] Protected health information ("PHI") is health information that is created or received by a health care provider, health plan, or health care clearinghouse which relates to: 1) the past, present, or future physical or mental health of an individual; 2) the provision of health care to an individual; or 3) the past, present, or future payment for the provision of health care to an individual. To be protected, the information must be such that it identifies the individual or provides a reasonable basis to believe that the information can identify the individual. 45 C.F.R. 164.508.

[2] These laws apply to health plans, health care providers,, and health care clearinghouses.

4. Specific description of the purpose for each use or disclosure (or write "At the request of the individual" in this space):

5. The method of releasing and delivering the information is:

Regular mail _____ Overnight Delivery_____

Hand Delivery_____ Fax_____ Telephone_____

6. I understand that I may revoke this authorization in writing at any time, except to the extent that the person(s) and/or organization(s) named above have taken action in reliance on this authorization.

7. This authorization expires on:_____(date)
(Note: Leave blank if no expiration date is necessary).

I have had the opportunity to read and consider the contents of this authorization. I confirm that the contents are consistent with my direction.

_____ _____
Signed Date
Name:

Address:_____

Telephone: _____ Social Security No.:_____

_____
Relationship or Authority of Personal Representative (if applicable)

_____
Witness