CENTRAL PENNSYLVANIA TEAMSTERS HEALTH AND WELFARE FUND

AUTHORIZATION FORM

By signing and submitting this form, I am authorizing the Central Pennsylvania Teamsters Health & 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)

Participant Alternate ID#: _____

_____

Signature of Participant or Dependent Date

I authorize the Central Pennsylvania Teamsters Health and Welfare Fund to disclose the information described below to the person or organization listed below (for example, Gladys Smith):

_____

Name of person/organization

_____

Address and telephone number

_____

Relationship of Authorized Individual to Participant or Dependent
(for example, my mother)

I authorize the Fund to disclose the information described below to my authorized representative (for example, the reasons that my claim for physical therapy benefits were denied).

_____

_____

_____

_____

- 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:

Psychotherapy Notes:	_____ (*Initials*)
Mental/Behavioral information	_____ (*Initials*)
Chemical dependency (*includes Alcohol/drug treatment)*	_____ (*Initials*)
HIV/AIDS	_____ (*Initials*)

Expiration Date of Authorization
This authorization is effective through ____/___/____ (maximum period of 90 days) unless revoked or terminated by me or my personal representative. This authorization will automatically expire ninety (90) days from the date of this authorization.

Right to Terminate or Revoke Authorization
You may revoke or terminate this authorization by submitting a written revocation to the Central Pennsylvania Teamsters Health & Welfare Fund. You should forward written communication to Lou Ann DeLong, Health and Welfare Benefits Manager, to terminate this authorization.

Potential for Redisclosure
Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under the federal privacy regulations.