SEIU LOCAL 1 & PARTICIPATING EMPLOYERS HEALTH TRUST

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Participant's Name: _____ SSN:_____
(Please Print)

Address:_____

Patient's Name: _____ Telephone:( )_____Home ( )_____Work

In the course of providing health plan coverage, the SEIU LOCAL 1 & PARTICIPATING EMPLOYERS HEALTH TRUST ("Trust") may obtain private health information about you or your dependent child(ren). Except as permitted by law and Federal regulations, the Trust will not disclose that private health information to any person or entity. If you would like your representative to assist you in obtaining benefits from the Trust, you can sign this Authorization Form. The Trust WILL NOT condition payment of a claim, enrollment in a plan or eligibility for benefits on your decision to sign this Authorization Form. You are not required to sign this form. However, if you do not sign it, your personal representative will be unable to assist you with your claim.

This Authorization Form is only effective if it is signed by the person whose medical information is to be disclosed, or by someone authorized to sign for that person. If the person whose medical information is to be disclosed is a child under age 18, a parent living with the child can sign on behalf of the child.

1. **Description of Health Information to Be Used or Disclosed.** In order to enable my representative to assist me in obtaining benefits from the Trust, I want this authorization to apply to all information concerning medical treatment arising out of my illness and/or injury occurring on or about _____. This authorization allows the Trust to disclose and use any health information arising out of the above-described illness or injury, unless I specify otherwise on the following lines. This authorization does not apply to: (Specify any element or category of health information that relates to the above-described illness or accidental injury, but which you do NOT want to be disclosed.)

   _____

   _____

   Also, this form does not authorize the disclosure, release or use of psychotherapy notes.

2. **Persons and Organizations Authorized to Disclose My Health Information.** This authorization applies to the Trust and the Medical Center, and to all of their employees, representatives and agents having access to my health information.

3. **Persons and Organizations Authorized to Receive and Use My Health Information.** (Check either line).

   _____ Any agents or representatives of myself, (or)

   _____ The following named agent(s) or representative(s):

   _____

   I understand that my agents and representatives are not health care providers or health plans that are subject to Federal privacy standards and that disclosing my health information pursuant to this authorization creates a risk of redisclosure without my authorization.

4. **Purpose of the Requested Use and/or Disclosure.** I authorize my health information to be used and/or disclosed for all purposes that SEIU Local 1 & Participating Employers Health Trust and/or its representatives, in their sole discretion, deem necessary or advisable to assist me in obtaining benefits from the Trust.

5. **Your Rights with Respect to This Authorization.** You have the right to revoke this authorization at any time. Any revocation must be in writing, sent or delivered to 111 E. Wacker Drive, 17th Floor, Chicago, Illinois 60601. A revocation will not be effective as to uses and/or disclosures of my health information that have already made in reliance upon this authorization prior to receipt of your written revocation. Also, if you sign this authorization, you will be provided with a signed copy of it.

6. **Expiration of Authorization.** Unless you insert an earlier date on the following line, this authorization will expire one year from the date on which you sign it.

   This authorization will expire on (date): Month:_____ Day:_____ Year: _____

7. **Authorization.** By signing this Authorization Form, I authorize the Trust and its agents and employees to disclose my health information, subject to the limitations contained in this Authorization Form. 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 on this form. I have had an opportunity to review, and I understand the contents of, this form.

_____	_____	_____
Signature	Print Name	Date

If authorization is signed by on behalf of another person, please complete the following.

Name of person: _____.

Relationship or nature of authority (for example, signer is a parent or guardian or has health care power of attorney):