SEIU LOCAL 1 & PARTICIPATING EMPLOYERS HEALTH TRUST

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Pa	rticipant's Name:		(Please Print) SSN:				
	. ———	(Please Print)					
Ad	dress:						
Pa	tient's Name:	Telephor	ne:()		Home ()	Work
HE Ex- info fro en rec	the course of providing heal EALTH TRUST ("Trust") may cept as permitted by law and ormation to any person or element in a plan or eligibility in	vobtain private health in the defension of the defension	nformatio the Trust vour repre The Trust decision to	n about you will not discl sentative to : WILL NOT o sign this Au	or your depe ose that priva assist you in condition pay uthorization F	ndent child te health obtaining l vment of a orm. You a	d(ren). benefits <u>claim,</u> are not
dis	is Authorization Form is only <u>closed,</u> or by someone auth disclosed is a child under a	orized to sign for that p	erson. If	the person v	whose medica	al informati	
1.	assist me in obtaining ben- concerning medical treatm This authorization allows the described illness or injury, apply to: (Specify any elen	Description of Health Information to Be Used or Disclosed. In order to enable my representative to ssist me in obtaining benefits from the Trust, I want this authorization to apply to all information oncerning 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-escribed illness or injury, unless I specify otherwise on the following lines. This authorization does not pply to: (Specify any element or category of health information that relates to the above-described illness r accidental injury, but which you do NOT want to be disclosed.)					
	Also, this form does not au	thorize the disclosure,	release o	r use of psy	chotherapy no	otes.	
2.	Persons and Organizatio authorization applies to the representatives and agents	Trust and the Medical	Center, a	and to all of t			
3.	Persons and Organization (Check either line).	ns Authorized to Rec	eive and	Use My He	alth Informa	tion.	
	Any agents or repre	esentatives of myself, (or)				
	The following name	ed agent(s) or represen	itative(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.

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This authorization will expire on (date): Month:		Day:	Year:						
disclose my health information that I am under no obligation to regarding the use and/or disclo	, subject to the limitations cont o sign this form. I have signed to osure of the health information	ained in this Authorization this form voluntarily to doc described on this form. I h	Form. I understand ument my wishes						
gnature	Print Name	 Date							
If authorization is signed by on behalf of another person, please complete the following.									
ame of person:									
Relationship or nature of authority (for example, signer is a parent or guardian or has health care power of attorney):									
	This authorization will expire of Authorization. By signing this disclose my health information that I am under no obligation to regarding the use and/or disclose opportunity to review, and I under the authorization is signed by on became of person:	This authorization will expire on (date): Month: Authorization. By signing this Authorization Form, I authorized disclose my health information, subject to the limitations contact that I am under no obligation to sign this form. I have signed to regarding the use and/or disclosure of the health information opportunity to review, and I understand the contents of, this formation opportunity to review, and I understand the contents of, this formation is signed by on behalf of another person, please ame of person: Authorization is signed by on behalf of another person, please ame of person: Authorization is a parent limitation will experience and the contents of the limitations contact the limi	This authorization will expire on (date): Month:						