AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that the information I am authorizing to be disclosed may be subject to redisclosure by the recipient and no longer be protected by federal privacy regulations.

Participant's name:____ **ID Number:**___________________

Persons/organizations providing information: ____

____

Persons/organizations receiving information: ____

____

Specific description of information (including date(s)): ____

____

____

Purpose of the use or disclosure: ____

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____

The participant or the participant's representative must read and initial the following statements:

a. I understand that Teamsters Joint Council No. 83 of Virginia Health & Welfare Fund may not condition my health care treatment, payment for my health care, enrollment in the health plan, or eligibility for benefits if I do not sign this form unless the Health & Welfare Fund needs my authorization to make eligibility or enrollment determinations about me for the Fund's underwriting or risk rating determinations. **INITIALS:**___________

b. I understand that I get a copy of this form after I sign it. **INITIALS:**___________

c. I understand that this authorization will expire on ___/___/_____, or upon the event of _______________________________. **INITIALS:**___________

d. I understand that I may revoke this authorization at any time by notifying the Privacy Officer at Teamsters Joint Council No. 83 of Virginia Health & Welfare Fund in writing, but if I do, it won't have any effect on actions the Fund took before it received the revocation. **INITIALS:**___________

____ _________________________

Signature of participant or representative Date

____ _________________________

Printed name of participant's representative Relationship to the participant