Teamsters Union 25 Health Services & Insurance Plan
16 Sever Street Charlestown, MA 02129
T: 617-241-9220 F: 617-242-6950

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

PARTICIPANT/PATIENT:

_____ _____
Name of Participant/Patient Date of Birth

_____ _____
Street Address City, State, Zip

AUTHORIZES:

_____
Name of Health Care Provider/Plan/Other

_____
Street Address

_____
City, State, Zip Code

RELEASE OF PROTECTED HEALTH INFORMATION TO:

_____
Name of Health Care Provider/Plan/Other

_____
Street Address

_____
City, State, Zip Code

INFORMATION TO BE RELEASED:

___ Medical History, Examination, Reports ___ Immunizations ___ Laboratory Reports
___ Dental Records ___ X-ray Report ___ Prescriptions
___ Consultations ___ Entire Record
___ Other (Specify): _____

In compliance with MA Statutes, which require special permission to release otherwise privileged information, please release records pertaining to:

___ Mental Health ___ Developmental Disabilities ___ Substance Abuse
___ HIV (AIDS) ___ Sexually Transmitted Disease
___ Other (Specify): _____

For the Following Date(s): _____

PURPOSE FOR NEED OF DISCLOSURE: (Check applicable categories)

___Further Medical Care ___Treatment Recommendations ___Assessment Summary
___Insurance Eligibility/Benefits ___Verification of attendance ___Discharge Summary
___Legal Investigation or Action ___Verification of Treatment progress ___Personal
___Changing Physicians
___Other (Specify): _____

I understand that if the person(s) and/or organization(s) listed above are not health care providers, health plans or health care clearinghouses, who must follow the federal privacy standards, the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and my health information may be redisclosed without obtaining my authorization.

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

Right to Inspect or Copy the Health Information to Be Used or Disclosed - I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization form. I may arrange to inspect my health information or obtain copies of my health information by contacting Teamsters Union 25 Health Services & Insurance Plan. **Right to Receive Copy of This Authorization -** I understand that if I agree to sign this authorization, which I am not required to do, I must be provided with a copy of the signed form. **Right to Refuse to Sign This Authorization -** I understand that I am under no obligation to sign this form and that the person(s) and/or organization(s) listed above who I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization. **Right to Withdraw This Authorization -** I understand written notification is necessary to cancel this authorization. To obtain information on how to withdraw my authorization or to receive a copy of my withdrawal, I may contact Teamsters Union 25 Health Services & insurance Plan. I am aware that my withdrawal will not be effective as to uses and/or disclosures of my health information that the person(s) and or organization(s) listed above have already made in reference to this authorization.

EXPIRATION DATE: This authorization is good until the following date(s) _____or for one year from the date signed.

I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.

PARTICIPANT/PATIENT/LEGAL REP. SIGNATURE: _____
(If signed by other than patient, state relationship and authority to do so.)

DATE: _____ **WITNESS:** _____

Complete, Sign and Return this Form to: Teamsters Union 25 Health Services & Insurance Plan, HIPAA Privacy Official, 16 Sever Street, Boston, MA 02129, Fax: 617-242-6950 or (EAP) FAX 781-321-6501 **Rev. 2014**