AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Participant/Patient Information:

Member Name	LAST 4 SSN	DOB
Address	City/State/Zip	
Phone Number	Email Address	

This authorization is to release the protected health information from:

Teamsters Union 25 Health Services & Insurance Plan	**Phone (617) 241-9220**
Schrafft's City Center, 529 Main St, Suite 209 Charlestown, MA 02129	**Fax (617) 241-8168**

This authorization is to release the protected health information to:

Name of Health Care Provider/Plan/Other:	
Address	City/State/Zip
Phone Number	Fax Number

Purpose for need of disclosure (check applicable categories):

□ **Further Medical Care** □ **Treatment Recommendations** □ **Assessment Summary** □ **Discharge Summary**
□ **Insurance Eligibility/Benefits** □ **Verification of Attendance** □ **Legal Investigation or Action** □ **Personal**
□ **Verification of Treatment Progress** □ **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 re-disclosed without obtaining my authorization.

General Information to be released:

□ **Medical History, Examination, Reports** □ **Immunizations** □ **X-Ray Report**
□ **Dental Records** □ **Prescriptions** □ **Entire Record**
□ **Consultations** □ **Laboratory Report**
□ **Other (Specify): _____ DATE(s) OF SERVICE:_____**

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

□ **Mental Health** □ **Substance Abuse** □ **Developmental Disabilities**
□ **HIV/AIDS** □ **Sexually Transmitted Disease**
DATE(s) OF SERVICE:_____

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 upon request. **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 that 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 upon 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 form is valid until the following date _____ or for one year from the date signed.

Participant/Patient Acknowledgement and Signature:

I have had the opportunity to review and understand the content of the authorization listed on page 1. By signing this form, I am confirming that it accurately reflects my wishes.

_____ _____ _____

Printed Name **Signature** **Date**

My signature must be notarized by a Notary Public. The date I sign must match the date on which my signature is notarized.

Statement of Notary NOTE: Notary seal must be visible

The consent to this authorization was subscribed and sworn (or affirmed) to before me on this _____day of _____, year _____, by (participant/patient)_____, who proved to me on the basis of satisfactory evidence to be the person who appeared before me, who affirmed that such consent represents his/her free and voluntary act.

_____ _____

Notary Public Signature **Date Commission Expires**

STAMP or SEAL ABOVE

Return completed form to:

Teamsters Union 25 Health Services & Insurance Plan
HIPAA Privacy Official
Schrafft's City Center
529 Main Street, Suite 209
Charlestown, MA 02129
Fax: (617) 241-8168