AUTHORIZATION TO USE/DISCLOSE HEALTH INFORMATION

The Name of Your Employer ____

The Social Security Number of the Employee ____________________________

I. Information About the Use or Disclosure

Individual's Name: ____

This authorization relates to the health plan(s) of ____________________ (hereinafter referred to as the "Plan"). I authorize the use or disclosure of my individually identifiable health information by or to my spouse, any health care provider, any insurer or claims administrator, or any other entity providing services in connection with the Plan in order to process my enrollment in the Plan or to process any claim for my Plan benefits. This authorization is effective until the date I terminate participation in the Plan.

II. Important Information About Your Rights

I have read and understood the following statements about my rights:

- I may revoke this authorization at any time before its expiration date by notifying Employer in writing, but the revocation will not have any effect on any actions the Plan took before it received the revocation.
- I may see and copy the information described in this authorization if I ask for it.
- I am not required to sign this authorization to receive my health care benefits (enrollment, treatment, or payment).
- The information that is used or disclosed pursuant to this authorization may be re-disclosed by the receiving entity.

III. Signature of Individual or Individual's Representative

______________________________ ______________________________

Signature of Individual or Individual's Representative   Date

(This form MUST be completed before signing)

Printed name of Individual's personal representative:________________________________

Relationship to the Individual, including authority for status as representative:

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