

**WESTERN PENNSYLVANIA TEAMSTERS AND EMPLOYERS WELFARE FUND
PARTICIPANT AUTHORIZATION FORM
ALLOWING COMMUNICATION/DISCLOSURE OF HEALTH INFORMATION**

Participant Name: _____ ID No. and/or Birth Date: _____

By signing this authorization form I authorize the Western Pennsylvania Teamsters and Employers Welfare Fund and its business associates (collectively "my health plan") use and/or disclose my health information described below to person(s) and/or organization(s) described below in the manner described below.

1. Description of Health Information I Authorize to be Used or Disclosed. The following is a specific description of the health information I authorize the Covered Entity to disclose to persons or entities described on this form. (If you want to limit your authorization to only apply in specific areas, such as: pharmaceutical information; x-rays; physical examinations; all claims or those relating to a particular incident; payment; or enrollment, you should specify that directive here and provide a meaningful description. For Example: I authorize my health plan to release my protected health information to my attorney, Mr. John Laws, as may be required in connection with a lawsuit relating to a motor vehicle accident which occurred on or about May 1, 2003.)

- I authorize my health plan to make unlimited disclosure to the person/entity I identify herein.
 My authorization is limited to the following type of information: _____

This authorization is for psychotherapy notes. (An authorization relating to psychotherapy notes must be submitted separately.)

2. Persons/Organizations I hereby Authorize to Receive and/or Use My Health Information.

Name of Participant's designated representative: _____

Address: _____

Phone: _____ Fax: _____

I authorize my health plan to disclose the health information described above in Section 1 of this form to the person(s) and/or organization(s) identified above for the purposes listed below in Section 3 of this form. I understand that if the person(s) and/or organization(s) listed above are not health care providers, health plans or health care clearinghouses subject to federal privacy standards, there is the potential that health information disclosed pursuant to this authorization may no longer be protected by the federal privacy standards and that such person(s) and/or organization(s) may redisclose my health information without obtaining my authorization.

3. Description of Each Purpose for the Requested Use and/or Disclosure. I authorize my health information to be used and/or disclosed for the following specific purposes: (choose one)

- Pursuant to the Participant's wishes. Other (please describe): _____

4. Expiration of Authorization. This authorization will expire):

- Until cancelled (This option is presumed to apply unless you select another option below.)

On ____/____/____, or
MM / DD / YR

- Upon the occurrence of the following event(s) related to my health care or to the purpose(s) for which I have authorized the use and/or disclosure of my health information described in Section 4 of this form: _____

