AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

ASEA/AFSCME Local 52 Health Benefits Trust

Address: 111 W. Cataldo, Suite 220, Spokane, WA 99201 • Phone: 866-553-8206 (toll-free); 509-328-0300 • Fax: 702-216-0885
Website: www.aseahealth.org

Use this form to authorize the ASEA/AFSCME Local 52 Health Benefits Trust to ***release*** personal health information that is protected by HIPAA Privacy Rules.

PLEASE PRINT CLEARLY **Required**

Information about the use or disclosure or protected health information. I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary and that I may revoke it at any time by submitting my revocation in writing to the ASEA/AFSCME Local 52 Health Benefits Trust Administrator.

Employee name: SSN or Alternate ID:

Patient name:

Persons/organizations authorized to provide the information: ASEA/AFSCME Local 52 Health Benefits Trust

Persons/organizations authorized to receive the information (for example, spouse or relative):

Specific description of information to be used or disclosed, including date(s); for example, health care claims, medical, dental, vision, utilization review:

Specific purpose of the disclosure (why is this disclosure needed):

Important information about your rights

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

- I may revoke this authorization at any time prior to its expiration date by notifying the Health Trust in writing, but the revocation will not have any effect on any actions the organization took before it received the revocation.
- I may see and copy the information described on this form if I ask for it.
- I am not required to sign this form to receive my health care benefits (enrollment, treatment or payment).

CERTIFICATION

I certify all information is true and correct.

Signature of patient or patient's representative: Signature Required Date:

Please print name:

Save a Copy Print Close