DISCLOSURE AUTHORIZATION FORM
FOR RELEASE OF PROTECTED HEALTH INFORMATION

Purpose: This form is used for an individual's request/authorization to release protected health information to a designated person or entity. Provider refers to the patient's physician or facility providing care (i.e. hospital, surgical facility, rehabilitation facility, skilled facility, physical therapy center, home health agency, equipment provider, pharmacy).

Member name:____________________ Member IDN#:________________

Covered person requesting/authorizing disclosure:________________________
Date of birth: Sex:
I,________________________, hereby request and authorize the provider,____________

________________________, to disclose and release: __________________

____

____

(describe kind and amount of information to be disclosed and date(s) of record to be disclosed)

at the request of and to: Med-Care Management, Inc.
(On Behalf of Tristate Teamsters Joint Fund) P.O. Box 20564
West Palm Beach, FL 33416-0564

For the purpose of:

____

____

(describe specific purpose of disclosure)

A copy of this authorization is available to me, or to my authorized representative, upon request and will serve as the original. I understand that if this information is received by individuals or organizations that are not health care providers, health care clearinghouses, or health plans or health plan business associates covered by federal privacy regulations, my information described above may be re-disclosed and no longer protected by federal privacy regulations. This authorization is subject to revocation at any time upon written notice to the provider except to the extent that the provider has already taken action on the disclosure provisions contained in this document.

If not previously revoked, this authorization will terminate on ________________________

(specify date, event or condition. If an event or condition is specified, the provider must be notified in writing of the even or condition for revocation to be effective)

This authorization will automatically expire one year from the signature date if termination is not identified as an earlier date in the statement above.

________________________________Date ______________________
(signature of individual requesting disclosure, if an adult; of parent/
guardian on behalf of minor; or of individual's legal representative, as applicable)
If a legal representative signs on behalf of the individual, a copy of the legal representative's authority must be attached to this form.

CONFIDENTIALITY NOTICE

This facsimile transmission (and/or the documents accompanying it) may contain confidential information. The information is intended only for the use of the individual or entity named above. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or the taking of any action in reliance on the contents of this information is strictly prohibited. If you have received this transmission in error, please notify us immediately by telephone to arrange for the return of the documents