

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Name of Patient Whose Records Are to Be	Released:	
Social Security Number of Patient:	ent:Patient's Birth Date:	
Telephone and/or email address of Patient	:	
Patient's Address:		
City:	State:	Zip:
Patient's Relationship to Teamster:		
Teamster's Name:		
Teamster's Social Security Number:		
AUTHORIZATION TO RELEASE INFO	PRMATION TO ANOT	HER PARTY
circumstances. You have the right to requ another family member); however, you m medical information about you to another revoke that permission in writing, at any	nest that the Plan release nust provide such permi party for a reason other time. In addition, you ne Alaska Teamster Wel	releasing protected health information except in very specific eyour protected health information to another party (such as ission in writing. If you authorize the Plan to use or discloser than treatment, payment or healthcare operations, you may may use this form to authorize another individual to receive lfare Trust, upon his or her request. A full description of the Employer Welfare Trust office.
		erminates under the Alaska Teamster Welfare Trust. Again r protected health information at any time, but it must be in
Any or all of the health information for the request:	e patient named above ı	may be released to the following person or persons upon their
Name:		Relationship:
Name:		Relationship:
X		

(Children residing in Alaska under the age of 14 do not need to sign the authorization form. Children residing outside Alaska under the age of 12 do not need to sign the authorization form, unless required by the state law where they reside. Children residing outside Alaska age 12 and over are required to sign the authorization form, unless the parent or guardian who wishes to authorize the release of the child's information provides evidence that state law does not require the child's signature.)

Date

Signature of Authorizing Patient (or Authorizing Parent or Guardian)