Authorization for Release of Health Information

This form is required for team members requesting funds for medical reasons.

By signing this authorization, the individual identified below (or the personal representative of such individual) authorizes the disclosure of protected heath information (PHI) to the United We Care Fund.

Name of the individual to whom the health information relates:

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Name of personal representative (if applicable):

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Authority/relationship of personal representative (if applicable):

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What health plan will provide this information? (Include name & address)

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Health information to be used and disclosed includes health insurance rates, explanation of benefits, provider invoices and notes, and any other claim information relating to the proposed uses of funds requested from the United We Care Fund. This authorization will expire after a final determination is made by the United We Care Fund regarding the team member's application for assistance.

The individual may revoke the authorization at any time by providing written notice to the health plan providing the PHI identified in this authorization but if the individual revokes this authorization, it won't have any effect on any actions taken before the revocation is received. Information disclosed as a result of this authorization may no longer be protected by federal privacy laws.

The individual releases the health plans from any and all liability relating to or arising out of the use or disclosure of health information that is authorized by this authorization.

I hereby authorize the use or disclosure of the Protected Health Information.

____ __________________________

Signature of Individual Authorizing/Personal Representative Date

Be sure to keep a copy of this authorization for your records.