PARTICIPANT AUTHORIZATION FORM:
USE OR DISCLOSURE OF P.H.I. BY A HEALTH PLAN

Teamsters Security Fund For Southern Nevada Hotel & Casino Workers

Participant Name: _____ Birth Date: _____

Participant Identification Number and/or Social Security Number: _____

Telephone Number: _____ (day) _____ (evening)

I hereby authorize Teamsters Security Fund to use and/or disclose my personal health information as described below.

Description of Health Information to be Disclosed. The following is a specific description of the personal health information I authorize *Teamsters Security Fund* to use or disclose:

_____

_____

_____

Persons/Organizations to Whom My Health Information May Be Disclosed. I authorize *Teamsters Security Fund* to disclose the personal health information described above to the persons or organizations specified below.

_____

_____

Description of Purpose(s) for the Authorized Use or Disclosure. I authorize *Teamsters Security Fund* to use or disclose my personal health information at my own request or for the other purposes described below:

☐ At my request *(check only if applicable)*.

☐ For the following purpose(s) *(describe)*:

_____

_____

_____

Expiration of Authorization. This authorization will expire *(choose and complete one)*:

☐ On *(specify date)*: _____.

☐ Upon the occurrence of the event(s) described below:

_____

_____

_____

Confirmation of Understanding.

I understand that I have the right to revoke this authorization at any time. I also understand that my revocation of this authorization must be in writing. To obtain a copy of an Authorization Revocation form I may contact the plan office at the address and/or telephone number at the top of this form. I am aware that my revocation will not apply to uses and/or disclosures of my personal health information that *Teamsters Security Fund* has already made in reliance upon this authorization.

I understand that if I sign this authorization, I must be provided with a signed copy of it.

I understand that I am under no obligation to sign this form, and that *Teamsters Security Fund* will not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization.

I understand that the health information disclosed pursuant to this authorization may no longer be protected by the federal privacy standards, and the person(s) and/or organization(s) who obtain my personal health information may be permitted to disclose it to someone else without my authorization.

By signing this form, I am confirming that it accurately reflects my wishes.

_____ _____

Signature of Participant or Personal Representative Date

If signed by a personal representative, complete the following:

Name of personal representative *(print)*: _____

Relationship to participant or nature of authority: _____

Return To
Teamsters Security Fund for Southern Nevada
Hotel and Casino Workers
P.O. 26779
Las Vegas, NV 89126