Authorization for Use or Disclosure of Health Information

This authorization is required for the Regional District Council Welfare Trust ("Trust") and its third party administrator to release your health information to someone other than yourself or for purposes outside the Trust's normal operations (treatment, payment of claims or healthcare operations). The recipients of this Authorization will rely on it to disclose your health information and you agree by signing this Authorization that the Trust and its third party administrator can release the health information identified herein in accordance with the terms of this Authorization. Please review it carefully.

Identify below, the individual whose protected health information will be disclosed:

Name_____ Date of Birth _____/_____/_____

Address:_____ SSN: _____/_____/_____

Covered Employee Social Security Number: _____/_____/_____

The information requested below must be provided for this Authorization to be effective.

1. Specify the health information to be released and/or used, including (if applicable) the time period(s) to which the information relates (such as "Information related to my knee surgery in May 2010") or specify "all health information".

_____

For information related to alcohol/substance abuse, HIV/AIDS, or mental health to be disclosed, you must sign here: _____

2. Specify purpose for which health information may be used or disclosed (if you are initiating the request, simply put "at the request of the individual").

_____

3. Specify the person(s) authorized to use and/or receive the health information described in No. 1.

_____

4. Specify when this Authorization expires (PLEASE NOTE: This Authorization will expire on December 31st of year following the year the form is completed, unless an earlier date is specified here.)

_____

Statement of Rights regarding this Authorization

I understand I am not required to sign this form and that the covered entity cannot condition treatment, payment, enrollment or eligibility on my decision to sign this form, except a health plan can condition enrollment in the Plan or eligibility for benefits on receiving an authorization if the purpose is to allow the health plan to obtain information it needs to make an eligibility, enrollment or underwriting decision. I understand that I have the right to revoke this authorization prior to the expiration date set out in No. 4 above by submitting a written request to revoke to: Ryan Stephens, Privacy Official, P.O. Box 4148, Portland, Oregon 97208. I understand a revocation will not apply to information that has already been used or disclosed in reliance on the Authorization. I further understand that once the information is disclosed pursuant to this Authorization, it may be re-disclosed by the recipient and no longer protected by the Health Insurance Portability Accountability Act of 1996 (HIPAA).

Signature_____ Date_____

If signed by personal representative, provide a description of your authority to act for the individual whose health information will be disclosed: _____

Please remit signed Form to:
The William C. Earhart Company, Inc., P. O. Box 4148, Portland, OR 97208