AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Department of Human Resources
Benefits Division
720 University Place
Evanston, IL 60208

INDIVIDUAL INFORMATION

LAST NAME:	FIRST NAME	SOCIAL SECURITY NUMBER:

PHONE	E-MAIL ADDRESS	HOME ADDRESS	CITY	STATE	ZIP

AUTHORIZATION

I hereby authorize the use or disclosure of my individually identifiable health information as described below. *I understand that this authorization is voluntary and that I may revoke it at any time by submitting my revocation in writing to the Plan identified below, except to the extent the Plan has already taken action in reliance on my authorization*

Persons/organizations authorized to disclose the information:

Persons/organizations authorized to receive the information:

Specific description of information to be used or disclosed (including benefit plan and date(s), if applicable):

Specific purpose of the disclosure:

Will the health plan requesting the authorization receive financial or in-kind compensation in exchange for using or disclosing the health information described above? No _ Yes (if Yes, please describe)

This authorization will expire: (Please specify date)

IMPORTANT INFORMATION ABOUT YOUR RIGHTS

I have read and understand the following statements about my rights:

- I may revoke this authorization at any time prior to its expiration date by notifying the Benefits Division at the address stated above but the revocation will not affect any actions that the Plan took before it received the revocation.
- I may see and copy the information described on this form if I ask for it
- I am not required to sign this form to receive my health care benefits under the Plan (enrollment, treatment or payment), except in limited circumstances. For instance, prior to enrollment in the Plan, I may be required to sign an authorization for eligibility or enrollment determinations or for the Plan's underwriting or risk rating determinations. However, I may be required to sign an authorization form as a condition to receiving other benefits not provided for under this Plan (such as workers' compensation, FMLA or disability leave).
- The information that is used or disclosed pursuant to this authorization may be redisclosed by the receiving entity. I have the right to seek assurances from the above-named persons/organizations authorized to receive the information that they will notredisclose the information to any other party without my further authorization.
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Signature of Participant	Date