

SCREEN ACTORS GUILD-PRODUCERS PENSION & HEALTH PLANS

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Please complete all sections of this form, sign and date the form, and send it to the Privacy Officer at the address shown on the letterhead:

Participant Name: _____ **Social Security Number:** _____

Address: _____

Name of Patient: (if not participant) _____

Home Telephone: _____ **Work Telephone:** _____

The undersigned hereby authorizes the Health Plan to use or disclose my health information as described in this authorization.

Name and Address of the person or organization authorized to receive the information.

Description of health information to be disclosed or used. Use back of form if necessary.

I understand that I have the right to revoke this authorization at any time by notifying the Privacy Officer, in writing, at the above address. I understand that such revocation is only effective after it has been received and logged by the Privacy Office. I understand that any use or disclosure made pursuant to this authorization prior to the revocation will not be affected by the revocation. I understand that after this information is disclosed, federal law might not protect it. Unless revoked by me sooner, this authorization shall expire (choose one of the following):

___ On _____ (enter specific date)

___ Upon the occurrence of the following event related to my health care or to the purpose for which I have authorized the use and/or disclosure described above:

Signature of Patient _____ **Date** _____

If a personal representative of the patient is executing this form, please provide an explanation and documentation supporting his/her authority to sign on behalf of the patient.