SOUTHERN TIER BUILDING TRADES BENEFIT PLAN
AUTHORIZATION FOR RELEASE OF INFORMATION

Authorization

I hereby authorize the Southern Tier Building Trades Benefit Plan to disclose my individually identifiable health information as described below. ***I understand that this authorization is voluntary and that I may refuse to sign this authorization, and that I may revoke it at any time by submitting my revocation in writing to the Southern Tier Building Trades Benefit Plan, 202 West Fourth Street, Jamestown, NY 14701.***

Name of person whose information will be disclosed pursuant to this authorization:

_____

Name of person(s) or organization(s) authorized to receive the information:

_____

_____

_____

Specific description of information to be disclosed, including date(s) and any conditions (if this is an authorization to disclose all health information, insert "all health information"):

_____

_____

_____

Specific purpose of the disclosure (if no specific purpose, insert "release information at the request of person(s) or organization(s) authorized to receive the information"):

_____

_____

_____

Date authorization to release information expires (insert specific state, time period (e.g., one year from date this authorization is signed), or event (e.g., upon termination of Plan coverage). **An expiration date is required**.

_____

Important Information About Your Rights

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

- This authorization is voluntary and I may refuse to sign it.
- I may revoke this authorization at any time by notifying the Southern Tier Building Trades Benefit Plan in writing, but the revocation will not have any effect on any actions taken by the Plan prior to its receipt of the revocation.

- Upon request, I may see and copy the information described on this form.

- I am not required to sign this form in order to receive Plan coverage or receive any health care benefit from the Plan.

- The information disclosed pursuant to this authorization may be disclosed by the person(s) or organization(s) authorized to receive it. I may seek assurances from those persons or organizations that they will not disclose the information to any other party without my further authorization.

Signature

_____ _____

Signature Date

If the person signing this authorization is a personal representative of person whose information will be disclosed:

Print name of personal representative: _____

Explain relationship to the person whose information will be disclosed pursuant to this authorization and authority to act for that person.

_____

_____