



CONSUMER DRIVEN HEALTH PLAN  
 NATIONAL ASSOCIATION OF LETTER CARRIERS  
**HEALTH BENEFIT PLAN**

20547 Waverly Court, Ashburn, Virginia 20149 • 703-729-4677 or 888-636-NALC (6252)  
 Brian L. Renfroe, President • Stephanie M. Stewart, Director



**Authorization for Release of Information**

**Section A** (to be completed by the NALC Health Benefit Plan)

Patient: \_\_\_\_\_  
 Member: \_\_\_\_\_  
 Member # \_\_\_\_\_

PHI to be released (include dates of visits/treatment): \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Purpose of use or disclosure of PHI: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

|                                       |                                       |
|---------------------------------------|---------------------------------------|
| PHI to be released by (name/address): | PHI to be released to (name/address): |
| _____                                 | _____                                 |
| _____                                 | _____                                 |
| _____                                 | _____                                 |

**Section B** (to be completed by the Patient or Patient's representative)

I hereby authorize the use and disclosure of my **protected health information (PHI)**, as described above. I understand that information released to a person or organization that is not a health care provider or health plan may no longer be protected by the federal privacy regulations. An asterisk (\*) beside the name of a person or organization in Section A above indicates the person or organization is not a health care provider or health plan.

I understand this Authorization is in effect as of the date I sign it and will remain in effect through \_\_\_/\_\_\_/\_\_\_ or for one year from the date of signature, whichever is earlier. Further, I understand that I may revoke this Authorization at any time by sending a written request to the attention of the Privacy Officer at the NALC Health Benefit Plan. The fact that I revoke this Authorization will not affect actions taken while the Authorization was in effect, before the Revocation is received.

If I am signing as the Patient's representative, I certify that I have authority to sign this Authorization. (If the patient is age 18 or older, he/she must personally sign this Authorization, unless the patient has authorized another person to act as representative.)

(signed) \_\_\_\_\_ Date \_\_\_\_\_  
*Patient or Patient's representative*

Relationship to Member: \_\_\_\_\_

**The NALC Health Benefit Plan does not sell or release individually identifiable health information for marketing purposes.**