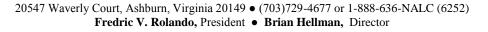
NATIONAL ASSOCIATION OF LETTERS CARRIERS



HEALTH BENEFIT PLAN





Authorization for Release of Information

Section A (to be completed by the NALC Hea	alth 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)
understand that information released to a plonger be protected by the federal privacy	of my protected health information (PHI), as described above. I person or organization that is not a health care provider or health plan may no regulations. An asterisk (*) beside the name of a person or organization in rganization is not a health care provider or health plan.
year from the date of signature, whichever time by sending a written request to the att	as of the date I sign it and will remain in effect through/ or for one is earlier. Further, I understand that I may revoke this Authorization at any tention of the Privacy Officer at the NALC Health Benefit Plan. The fact that I ions taken while the Authorization was in effect, before the Revocation is
	tive, I certify that I have authority to sign this Authorization. (If the patient is gn this Authorization, unless the patient has authorized another person to act
(signed)	
Patient or Patient's representa	ative Date
Relationship to Member:	

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