CHECK APPLICABLE PLAN(S):

Print Form

☐ **JEFFERSON FEDERATION OF TEACHERS HEALTH AND WELFARE PLAN (the "Plan")**

and/or

☐ **JEFFERSON FEDERATION OF TEACHERS CAFETERIA PLAN (the "Plan")**

AUTHORIZATION FOR USE AND/OR DISCLOSURE OF HEALTH INFORMATION

I, _____ , hereby authorize the Plan to use or disclose my health information as described in this authorization.

(1) Specific description of the health information I authorize to be used or disclosed:

(2) Specific person(s) or class of persons to whom the Plan may disclose the health information for their use:

(3) Purpose of the request (either check "At my request" or state the reason):

☐ At my request, **or** for the reasons stated below:

(4) I understand that this authorization will terminate when I am no longer covered by the Plan unless I state below an earlier termination time or event, or at any time that I file a written revocation:

(5) *Right to revoke:* I understand that I have the right to revoke this authorization at any time by written notification to the Plan at the address listed below. I also understand that a revocation is effective only after it is received and logged by the Plan. I understand that any use or disclosure made under this authorization before it is revoked will not be affected by my revocation.
(6) I understand that the Plan will not condition treatment, payment, enrollment or eligibility for benefits on my providing this authorization.
(7) I understand that after health information is disclosed under this authorization, federal privacy rules may no longer protect it, and the recipient might disclose it again.
(8) I understand that I am entitled to a copy of this signed authorization.

Signature of Participant/Beneficiary or Personal Representative Date

Name

Address

Telephone Number

Social Security Number

Name & Social Security Number of Employee/Retiree if different from above:

Name Social Security Number

If signed by a Personal Representative, the Personal Representative warrants that she/he is authorized to sign on behalf of the Participant/ Beneficiary based on the following authority:

AUTHORIZATION MUST BE FILED WITH THE FOLLOWING PERSON:
Administrator/Privacy Officer
2540 Severn Avenue, Suite 302
Metairie, LA 70002
Phone: 504-455-7261
Fax: 504-455-7267