

**AUTHORIZATION FOR RELEASE OF PROTECTED
INDIVIDUALLY IDENTIFIABLE INFORMATION**

I. Information about the use or disclosure of protected health information

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary and that I may revoke it at any time by submitting my revocation in writing to Administration Services, Inc. PO Box 5434, Spokane, WA. 99205.

Participant name: _____ SS# _____

Patient name: _____

Persons/organizations authorized to provide the information:

Washington Idaho Carpenters Health and Security Trust, Administration Services, Inc. and Medical Rehabilitation Consultants.

Persons/organizations authorized to receive the information (for example, spouse or relative):

Specific description of information to be used or disclosed, including date(s):

for example; health care claims: medical, dental, vision, utilization review.

Specific purpose of the disclosure (why is this disclosure needed):

This authorization will automatically expire one year from the date signed unless you indicate a shorter time period. _____

II. Important Information About Your Rights

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

- I may revoke this authorization at any time prior to its expiration date by notifying the providing organization in writing, but the revocation will not have any affect on any actions the organization took before it received the revocation.
- I may see and copy the information described on this form if I ask for it.
- I am not required to sign this form to receive my health care benefits (enrollment, treatment, or payment).

Signature of patient or patient's representative

Date

Please print name