AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I. Information About the Use or Disclosure

I hereby understand that the Conservation Employees' Insurance Trust Fund (the "Plan") may use and disclose protected health information ("PHI") about me for purposes of health care treatment, health care payment and health care operations without my authorization or opportunity to agree or object to the use or disclosure in accordance with the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA"). However, I request to restrict use and disclosure of PHI concerning treatment, payment and health care operations about me, or to restrict disclosures to family members, relatives, friends or other persons identified by me who are involved in my care or payment for that care.

II. Plan Information

Department designee(s) within the Human Resources office to whom the "Plan" can disclose protected health information are: Compensation Manager, Human Resources Specialist, Human Resources Services Analyst and Human Resources Technician.

The Privacy Official is the Compensation Manager.

III. Password Protection

Would you like to have your account password protected?

If yes, what would you like for your password?

IV. Disclosure Authorization

Please list the name of each organization or individual, outside of the personnel listed in Item II, to whom you would like the Department designees to disclose protected health information. (With respect to another business entity, indicate the name of business as well as the contact person.) Also, describe the type of information that you would like the Department designees to disclose to that organization or individual, *i.e., Betty Doe, All Information.* In addition, indicate the reason for the requested disclosure (you may simply state "at my request").

Name(s)	Information Department Designee(s) May Disclose/Reason Disclosure is Requested

If you need to add additional names, please list on a separate sheet of paper and attach to this form.

V. Special Instructions

Special instructions for handling confidential communications:

VI. Revoking of Authorization

This authorization will expire on: (indicate a date or an event relating to you personally)

Over

VII. Other Important Information

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

I may revoke this authorization at any time prior to its expiration date by notifying the Conservation Employees' Insurance Trust Fund in writing, but the revocation will not have any affect on any actions the entity 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).

The information that is used or disclosed pursuant to this authorization may be redisclosed by the receiving entity. I have the right to seek assurances from the above-named persons/organizations authorized to receive the information that they will not redisclose the information to any other party without my further authorization.

VIII. Signature of Member or Member's Representative

(This form MUST be completed before signing.)

_____ _____

Signature of member or member's representative Date

Printed name of member:

Printed name of member's personal representative:

Relationship to the member, including authority for status as representative :

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION