HOOSIER SCHOOL BENEFIT TRUST
AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize the use or disclosure of my individually identifiable health information as described below. The Hoosier School Benefit Trust Health Plan (the "Plan") may use or disclose PHI as set forth in this Authorization. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

Name of Participant: _____ **SS Number:** _____

Address: _____

Persons/Organizations authorized to receive the information: _____
_____
_____

Specific description of information (including date(s)): _____
_____
_____

Specific purpose of the use or disclosure: _____
_____
_____

Expiration date of authorization: _____ *or upon termination of enrollment in the health plan.*

I understand that the Hoosier School Benefit Trust Health Plan will not condition payment, enrollment or eligibility for benefits on my signing of this authorization. I understand that I may generally revoke this authorization at any time by notifying the Plan in writing, but the revocation will not have any effect on any actions that the entity took before it received the revocation. The information that is used or disclosed pursuant to this authorization may be re-disclosed by the receiving entity; however, the receiving entity (if an employee of the school corporation) shall not disclose this information to any other employee in the school corporation without your consent.

I understand my rights and hereby authorize the use or disclosure of my individually identifiable health information as set forth herein.

_____ _____
Signature of Participant or Personal Representative **Date**

PERSONAL REPRESENTATIVES ONLY

Printed name of participant's representative: _____
Relationship to the participant: _____