Authorization For Release of Protected Health Information

- **Crete Carrier Corp.**
- **Shaffer Trucking**
- **Hunt Transportation**

AUTHORIZATION FORM COMPLETION INSTRUCTIONS

1. Complete Authorization in full with black ball point pen.
2. Retain a copy for your records and return the original Authorization to the Crete Carrier Corporation Benefits Department.

CRETE CARRIER CORPORATION GROUP HEALTH PLAN

Attention: Benefits Department
400 NW 56th Street
Lincoln, NE 68528
Fax Number: 402-479-2579

ID:

Sub. Last Name:

DOC:

Acronym:

OFFICE USE ONLY

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

This form authorizes the Crete Carrier Corporation Group Health Plan (the "Group Health Plan") to release your Protected Health Information. You only need to complete this form if you want the Group Health Plan to give your Protected Health Information to another person or organization, such as your spouse. "Protected Health Information" (PHI) is information about you that may identify you and relates to your past, present or future physical or mental health or condition and related health services. Please print clearly in blue or black ink.

SECTION A: **Individual authorizing release of PHI**

Your Social Security Number

☐☐☐-☐☐-☐☐☐☐

Your Name: _____

Your Telephone Number: (Day) _____ (Evening) _____

Your Address: _____
Street Apartment #

_____
City State ZIP Code

SECTION B: **Description of Authorization**

I hereby authorize the Group Health Plan to release my Protected Health Information (PHI) as described in this authorization. I understand that my PHI may include, but is not limited to, the following: medical records, emergency care records, billing statements, prescription records, Explanation of Benefits, diagnostic imaging reports, transcribed hospital reports, laboratory reports, dental records, pathology reports, physical therapy records, hospital records (including nursing records and progress notes), and any personal or medical information related to the purpose of this authorization.

I further understand that my PHI may include information related to any of the following: genetic testing, mental health (excluding psychotherapy notes), HIV/AIDS, prescription medication, pregnancy/maternity, organ transplants, and chemical dependency (including alcohol and drug treatment).

I further understand that this authorization applies to **ALL PHI**, except for the following limitations (if none, please leave blank): _____

SECTION C: **Persons/Organizations authorized to receive my PHI**

Please tell us who you are authorizing to receive your PHI by completing the table below.

- For "Person's Relationship To You" please give a general description such as "husband" or "attorney."
- The "Start Date" is the date this authorization will begin.
- The "End Date" is the date this authorization will end. If you do not want this authorization to end on a specific date, please check the "Upon Disenrollment" box. If you leave both the "End Date" **AND** "Upon Disenrollment" boxes blank, this authorization will remain valid until your disenrollment from your health plan.

Individuals Authorized to Receive Your PHI

Name of Person to Receive PHI	Person's Relationship To You	Address	ZIP Code	Telephone Number	Start Date	End Date	Upon Disenrollment

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Purpose for which release is to be made **(NOTE: you are not required to provide a specific purpose; if left blank, the Group Health Plan will presume that the release is simply being made at your request):** _____

_____

SECTION D: **Terms and Conditions of this Authorization**

I understand that I may refuse to sign this authorization. I understand that the Group Health Plan may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization. I also understand that if the person(s)/organization(s) authorized to receive my PHI is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations. I further understand that I may revoke this authorization in writing at any time, except to the extend that action has been taken in reliance upon this authorization (please contact the Group Health Plan at the address or telephone number listed below to obtain the standard authorization revocation form). Unless revoked earlier, this authorization will end on the date specified above or upon my disenrollment from the health plan.

SECTION E: **Your Signature**

Signature of Individual: _____ Date: _____

If this authorization is signed by a personal representative on behalf of the individual, please complete the following:

Personal Representative's Name: _____

Relationship to the member (check one of the following): ❑ Parent ❑ Legal Guardian* ❑ Holder of Power of Attorney*

* Please attach legal documentation if you are the legal guardian or Holder of Power of Attorney

Please return completed and signed form to the following address:

CRETE CARRIER CORPORATION
GROUP HEALTH PLAN

Attention: Benefits Department
400 NW 56th Street
Lincoln, NE 68528
Fax Number: 402-479-2579

If you have questions, need additional information or assistance in completing this form, please contact us at the above address or

Toll Free 1-800-998-8005