AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Name: ____________________________ SS# or Member ID: _____________________

Party Authorized to Disclose Information: **CEBT – WTW**

Party Authorized to Receive Information: ________________________________

Description of Information: ____
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Purpose for Disclosure: ____
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I hereby authorize the use or disclose of information, as described above. I understand that:

- This authorization is voluntary;
- The information, once disclosed, may potentially be redisclosed by the recipient and no longer subject to the protection of the Privacy Rule;
- The disclosing party cannot condition my treatment or eligibility for benefits on the signing of this authorization;
- If the disclosing party has asked for this authorization, it will provide me with a copy of the signed authorization;
- I may revoke this authorization at any time by notifying the disclosing party in writing, and such revocation will not affect actions taken by the disclosing party prior to its receipt of my revocation; and
- If applicable, this authorization will expire _________________ from the date signed.

____ ____________
Signature of Individual or Individual's Personal Representative Date

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If signature is Personal Representative, please indicate relationship or authority to act for Individual.