AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

To: Southern Illinois Laborers' & Employers Health & Welfare Fund
5100 Ed Smith Way; Suite A; Marion, Illinois 62959

Patient's Name ______________________________________ SSN __________________

Patient Address, City/State/Zip____

I, __________________________, do hereby request that you release to the person(s) or entity listed below, information related to (a) my past, present or future physical health or condition; (b) information related to the provisions of my health care; and (c) information related to the past, present of future payment for the provision of my health care. The information is to be provided only to the following person(s) or entity:

Person receiving information ____
Relationship to Patient ____
Address, City,State/Zip____
Phone Number ____

I may revoke this authorization at any time by sending written notice of revocation to Southern Illinois Laborers' & Employers Health & Welfare Fund at the above address. Such revocation shall not be effective until received by Southern Illinois Laborers' & Employers Health & Welfare Fund and shall not apply to any disclosures made in reliance or this authorization prior to the revocation.

I acknowledge and understand that information disclosed in connection with this authorization may be subject to re-disclosure by the recipient, and any such re-disclosure will not be protected by the federal privacy standards.

This authorization shall expire on ________________________ (If left blank, two (2) years from the date form is received at the Fund Office)

IN WITNESS WHEREOF, I have hereunto set my hand this ____ day of ___________, 20-___.

____ (Signature of Patient)

State of _________________________ County of _________________________________