NBA Voluntary Employees Beneficiary Association

NBA VEBA AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Purpose: This form is used to authorize us to disclose protected health information or for another person to disclose protected health information to us for the purpose stated. You only need to complete this form if you want NBA VEBA to give your Protected Health Information to another person, such as your spouse or your employer.

Individual authorizing use and/or disclosure.

Name: ____________________ SS#____________________

Address: ____________________ Telephone #____________

Purpose for which authorization is being made: (NOTE: you are not required to provide a specific purpose; if left blank, NBA VEBA will presume that the release is simply being made at your request):

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Entities Authorized to Receive: Name or specifically identify the persons and/or organizations (family members, employer, etc.) to whom you are authorizing the disclosure and subsequent use of the protected health information described above:

____________________ ____________________

____________________ ____________________

Expiration: This authorization will expire (complete one):

On ____/____/______ **OR** __________On Disenrollment from program

Terms and Conditions: This authorization is voluntary. I understand that NBA VEBA will not condition my enrollment in a health plan, eligibility for benefits or payment of claims on giving this authorization. The protected health information may be disclosed to and/or received by persons or organizations that are not health plans, covered health care providers or health care clearinghouses subject to federal health information privacy laws. They may further disclose the protected health information, and it may no longer be protected by federal health information privacy laws. I understand that I may revoke this authorization at any time by giving written notice of my revocation to the office listed below. I understand that revocation of this authorization will *not* affect any action you took in reliance on this authorization before you received my written notice of revocation.

INDIVIDUAL'S SIGNATURE

I, ______________________________, have had full opportunity to read and consider the contents of this authorization, and I understand that, by signing this form, I am confirming my authorization of the use and/or disclosure of my protected health information, as described in this form.

Signature: ____________________ Date:____________________

If this authorization is signed by an authorized third party on behalf of the individual, complete the following:

Personal Representative's Name:____________________

Relationship to Insured: (check one of following): ___ Parent ____Legal Guardian ____Holder of Power of Attorney

Attach legal documentation if you are a legal guardian or Holder of Power of Attorney

Return completed and signed authorization to NBA VEBA Privacy Officer,
P.O. Box 80008, Lincoln, NE 68501-0008