WESTERN GROCERS EMPLOYEE BENEFITS TRUST

MEDICAL INFORMATION RELEASE FORM

I authorize the use and disclosure of my protected health information as described below.

PRINT YOUR NAME _____DATE OF BIRTH _____/_____/_____

SUBSCRIBER NAME: ☐ same_____ MEMBER # _____

My protected health information is individually identifiable health information, including demographic information, collected from me or created or received by a health care provider, a health plan, my employer, or a health care clearinghouse and that relates to: (i) my past, present, or future physical or mental health or condition; (ii) the provision of health care to me; or (iii) the past, present, or future payment for the provision of health care to me..

Release of Information

☐ I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

- ☐ Spouse: _____
- ☐ Child(ren): _____
- ☐ Other: _____
- ☐ Information is not to be released to anyone.

Communication / Messages

Please call: ☐ my home ☐my work ☐my cell Number:_____

If unable to reach me:

☐ You may leave a detailed message

☐ Please leave a message asking me to return your call

☐ Other: _____

The best time to reach me is (*day*)_____ between (*time*)_____and _____

Signed: _____ Date: ____/____/_____

Witness:_____ Date: ____/____/_____

I understand this authorization will remain in effect until revoked, and that I may revoke this authorization at any time by sending a written notification to Western Grocers Employee Benefits Trust, P.O. Box 22166, Portland, OR 97269, and this revocation will be effective for future uses and disclosures of protected health information.

_____ _____

Signature of Individual or Personal Representative Date

Western Grocers Employee Benefits Trust c/o Cypress Benefit Administrators
▪ PO Box 22166 ▪ Portland, OR 97269
Or FAX: 503.968.2817