Local 705 International Brotherhood of Teamsters Pension Plan
1645 West Jackson Boulevard, Chicago, Illinois 60612 (312)738-2811

Date: _____

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION AND RECORDS

The HIPAA Privacy Rules (federal regulations that became effective April 14, 2003) provide important protection for health information including that your authorization is obtained in certain circumstances. The Privacy Rules apply to the use and disclosure of Protected Health Information (PHI) by entities providing medical care and treatment.

NAME: _____ SSN: _____

ADDRESS: _____

TELEPHONE #: _____ DATE OF BIRTH: _____

The purpose of this authorization is solely for the processing and determining my eligibility for a Disability Pension benefit that I have applied for with the Local 705 I.B.T. Pension Fund. I understand that this authorization can be revoked at any time. To revoke this Authorization, you must submit it in writing to the Pension Fund at the address below. I HEREBY AUTHORIZE THE RELEASE OF MEDICAL INFORMATION AND RECORDS TO:

Local 705 I.B.T. Pension Fund
1645 West Jackson Blvd.
Chicago, IL 60612

I understand and agree that the information pertaining to my disability/medical condition may be released.

_____ _____
Signature Date

Rev. 8//2017

****NOTE: THIS IS NOT AN AUTHORIZATION TO BILL THE LOCAL 705 I.B.T. PENSION FUND FOR COPYING CHARGES FOR MEDICAL RECORDS. ANY COSTS ARE THE RESPONSIBILITY OF THE PATIENT. THANK YOU.**