SEAFARERS HEALTH AND BENEFITS PLAN

5201 Auth Way
Camp Springs, Maryland 20746-4275
(301) 899-0675

Margaret R. Bowen
Administrator

AUTHORIZATION TO RELEASE HEALTH INFORMATION

I, _____, last 4 digits of SSN _____ OR Date of Birth _____ authorize the Seafarers Health and Benefits Plan ("Plan") to disclose the following protected health information: (for example: records of physical examinations, claims history or benzene test results)

_____

_____

I give the Plan permission to disclose this information to the following person or entity (include name and address):

_____

_____

I am giving my permission to disclose the information listed above for the following reason(s): (for example: for a lawsuit, for employment purposes, for medical evaluation and treatment, or to help process my health claims)

_____

_____

I understand that I have the right to revoke this Authorization at any time. I must revoke in writing, either by a letter addressed to the Plan's Privacy Officer, 5201 Auth Way, Camp Springs, MD 20746, or by using the Plan's Revocation Form. Copies of the Revocation Form are available from the Plan's Privacy Officer. I understand that if I revoke this Authorization (or refuse at any time to sign an authorization to release my protected health information) it will not affect my eligibility for benefits from the Plan.

This Authorization shall remain in effect for one (1) year from the date listed below.

_____ _____
Signature Date

_____
Print