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 TO PORT OFFICIAL

I, ______________________________, Social Security # _____________ authorize the Seafarers Health and Benefits Plan ("Plan") to disclose the following protected health information:

(For example: information concerning a diagnosis of drug or alcohol dependence/abuse)

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I give the Plan permission to disclose this information to officials at the following Port(s):

(Note: You may limit disclosure to a particular official if you wish.)

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I am giving my permission to disclose the information listed above for the following reason(s):

(For example: to facilitate treatment, to process my grievance, for employment purposes, or to help process my health claims)

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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.

If no earlier expiration date is listed, this Authorization shall remain in effect for one (1) year from the date I signed this document.

________________________	________________________
Signature	Date signed
________________________	Expiration date: ________________
Print name	