SEAFARERS HEALTH AND BENEFITS PLAN
AUTHORIZATION TO RELEASE HEALTH INFORMATION

I, ________________________, Social Security # _________________, authorize the Seafarers Health and Benefits Plan (APlan@) to disclose the following protected health information: (for example: records of physical examinations, claims history or benzene test results)

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I give the Plan permission to disclose this information to the following person or entity:

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I am giving my permission to disclose the information listed above for the following reason(s): (for example: for a lawsuit, 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 effect my eligibility for benefits from the Plan.

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

______________________________ ______________
Signature Date

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Print name