



A CENTRAL STATES HEALTH PLAN

**AUTHORIZATION TO ALLOW USE AND DISCLOSURE  
OF PROTECTED HEALTH INFORMATION**

Participant's Identification Number or  
Social Security Number:

---

Participant's Name:

---

Your Name  
(if you are not the Participant):

---

Your relationship to the Participant  
(if you are not the Participant):

---

Describe the health information you are authorizing TeamCare to release:

Describe the purpose of the use and disclosure of the information:

Name, address and telephone number of the person to whom you want the information released:

Effective date of your authorization:

---

Expiration date of your authorization:

---

I understand I have the right to revoke this authorization. I understand that once the information described above is released, TeamCare will no longer be able to protect its confidentiality. I understand that TeamCare may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization.

Today's Date: \_\_\_\_\_

Participant Signature: \_\_\_\_\_

**NOTE:** If health information for both  
Participant and spouse needs  
to be released, both must  
sign.

Print Name: \_\_\_\_\_

Spouse Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_

Please mail the completed form to:

Privacy Officer  
TeamCare  
PO Box 5125  
Des Plaines IL 60017-5125

Or fax to: 847-518-9789