TEAMCARE®
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