

REQUEST A COPY OF HEALTH AND WELFARE 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):		
Please describe what specific health information you are requesting and for whom?		
Name and address to which TeamCare should forward this information:		
Today's date:	Your 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