

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I _____ hereby authorize the use or disclosure of my health information as described in this authorization.

- (1) *By General Synod Associate Reformed Presbyterian Health Benefit Plan*
- (2) *To _____*
- (3) *For the purpose of _____.*
- (4) *Right to revoke: I understand that I have the right to revoke this authorization at any time by notifying General Synod Associate Reformed Presbyterian Church, 1 Cleveland Street, Suite 110, Greenville, SC 29601. I understand that the revocation is only effective after it is received and logged by General Synod Associate Reformed Presbyterian Health Benefit Plan. I understand that any use or disclosure made prior to the revocation under this authorization will not be affected by a revocation.*
- (5) *I understand that after this information is disclosed, federal law might not protect it and the recipient might redisclose it.-*
- (6) *I understand that I am entitled to receive a copy of this authorization.*
- (7) *I understand that this authorization will expire when a determination has been made on the matter for which this authorization is made.*

Signature of Employee

Date

Personal Representatives section

If a Personal Representative executes this form, that Representative warrants that he or she has authority to sign this form on the basis of:

Return Completed Form To:

General Synod ARP Health Benefit Plan
Attn: Ed Hogan, Privacy Officer
1 Cleveland Street, Ste. 110
Greenville, SC 29601

For Questions Call: Ed Hogan, 1-864-268-3290, ext 224