LIVERMORE VALLEY
JOINT UNIFIED RETIRED EMPLOYEE HEALTH BENEFIT FUND

2610 Crow Canyon Road, Suite 200 • P.O. Box 2305 • San Ramon, CA 94583
Phone: (925) 208-9984 • Fax (925) 362-8564
staff@Lvrebenefitfunds.org • www.Lvrebenefitfunds.org

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Name: _____ SSN: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____

I authorize the Livermore Valley Joint Unified Retired Employee Health Benefit Fund , and its business associates to disclose Protected Health Information (claims, payment, eligibility and other related health information) about me to the following persons (select 1-2 persons if desired) at the request of such persons for benefit and claims inquiries:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I understand that this authorization will expire on December 31, 2010, unless I revoke it sooner. I understand that I have the right to revoke it at any time, except to the extent that it has already been relied upon. I understand that if I decide to revoke this authorization, I must give notice of my decision in writing and send it to:

Livermore Valley Joint Unified Retired Employee Health Benefit Fund

P O Box 2305

San Ramon, CA 94583

I understand that my health information that is disclosed pursuant to this authorization may be redisclosed by the persons I have identified above, and the Plan cannot prevent such redisclosures, AND I understand that I am not required to sign this form to receive my health care benefits.

Signature of Member: _____

Date: _____

OR

_____ I do not want my Health Information Released to anyone but myself.

Signature of Member: _____

Date: _____