TEACHERS HEALTH TRUST
FOR TEACHERS BY TEACHERS

CONSENT TO DISCUSS/DISCLOSE PERSONAL PROTECTED HEALTH INFORMATION (PHI)

HIPAA and Federal law prohibits discussing patient information without express written consent from the patient. If you would like the Teachers Health Trust to discuss your medical care and treatment with someone other than yourself, please list the names of those individuals below. Please be aware that you may add or remove names from this list at any time with written notice. As an added security measure, persons on this list must be able to verify your date of birth.

Participant Name: _____
PLEASE PRINT

Trust ID Number: _____

Date of Birth: _____

I hereby authorize the use and/or disclosure of my individually identifiable health information to the individuals listed below.

	Name of Person to Receive PHI	Date of Birth & Relationship to Participant
1.		
2.		
3.		
4.		
5.		

BY MY SIGNATURE BELOW, I ACKNOWLEDGE THAT I AM ALLOWING THE REPRESENTATIVES OF THE TRUST TO DISCUSS MY PERSONAL PROTECTED HEALTH INFORMATION INCLUDING, BUT NOT LIMITED TO, DIAGNOSIS, TREATMENT OPTIONS, AND THE STATUS OF MY INSURANCE. I ALSO UNDERSTAND THAT THE RELEASED INFORMATION MAY BE REDISCLOSED BY THE PERSONS NAMED ABOVE WITHOUT MY AUTHORITY.

_____ _____
Participant Signature *Date*