C&O EMPLOYEES' HOSPITAL ASSOCIATION

PERMISSION TO DISCLOSE
HEALTH INFORMATION TO DESIGNATED RECIPIENT

PART I PARTICIPANT INFORMATION

Name:

Address:

Identification Number

PART II DESIGNATED RECIPIENT OF HEALTH INFORMATION

I understand that federal law generally prohibits the C&O Employees' Hospital Association (the "Plan") from disclosing my personal health information to a family member, relative, personal friend, or other individual unless I have the opportunity to agree or object to the disclosure.

By signing below, I hereby agree to permit the Plan to disclose to the individual or individuals identified below my personal health information that is directly relevant to such designated person's involvement with my health care or payment related to my health care. I also agree to the disclosure of my personal health information to such individuals for purposes of notifying, or assisting in the notification of (including identifying or locating) such individuals of my location, general condition, or death.

I understand that I may revoke this permission at any time and/or object to any particular disclosure of health information.

I understand that I am not required to provide permission to disclose health information and that my eligibility for Plan benefits is not conditioned on my completion of this form.

I understand that the Plan generally will not disclose any health information to the individual(s) designated below except in accordance with Part III.

Designated Recipients of Health Information

Name of Designated Recipient	Telephone Number of Designated Recipient	Relation to Member