TEAM Wellness at Work

Authorization for Release of Protected Health Information

1. Member Information

Member's Name: _____ Birthdate: _____

Street Address: _____ Phone #:_____

City, State, Zip: _____ Work Phone #:_____

Maiden/Other names: _____

I, _____, voluntarily authorize TEAM Corporation,

☐ To Disclose: ☐ To Receive From: ☐To Exchange With:

2. The following person/organization:

Name: _____

Organization (if applicable): _____

Phone: _____

Fax: _____

Address/E-mail: _____

3. Specific description of the information to be disclosed. Check the following:

☐Appointment Verification ☐ Compliance Status ☐ Return to Work Notice

☐ Client Demographics ☐ Clinical Information ☐ Other: _____

The following information requires specific consent by law. Even if you indicate all health information, you must specifically request the following information in order for it to be released:

☐ Alcohol/Drug Abuse Treatment Records ☐Counseling Records

4. The purpose of this request is:

☐ Formal Referral ☐ Coordination of Care/Treatment ☐ Referral for Treatment

☐ Informal Referral ☐ Other: _____

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5. Acknowledgement

- I understand that information to be released or disclosed under this Authorization may be confidential in nature, and may include clinical impressions and clinical conclusions of providers.
- I understand the following consequences may occur by refusing to sign this release: 1) If Authorization is to demonstrate to a health plan that a service should be paid for, the health plan may refuse to pay for it; and 2) If the Authorization is sought by an insurer because I am seeking enrollment or eligibility, the insurer may deny me coverage.
- This Authorization becomes effective on the date I sign it, and will continue in effect for twelve (12) months from the date unless I revoke it in writing before that time. I understand I can revoke this authorization at any time, but information released before revocation cannot be retrieved. I may revoke this Authorization by sending a written revocation to: Privacy Officer, TEAM Corporation, 3601 Minnesota Drive, Suite 400, Edina, MN 55435
- I acknowledge the potential that the information disclosed pursuant to this Authorization may be subject to redisclosure by the recipient, and thus no longer protected by federal health information privacy laws.
- I understand that TEAM will not limit treatment under, payment for, enrollment in and eligibility for TEAM benefits based on my agreement or refusal to sign this Authorization
- I agree that a photocopy or facsimile (fax) copy of this Authorization is as valid as the original.
- I understand TEAM Corporation will give me a copy of this Authorization.

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6. Signature(s)

Signed: _____ Date: _____

If the Client is a minor, I authorize the release of the above information.

Signed: _____ Date: _____