SEAFARERS HEALTH AND BENEFITS PLAN
AUTHORIZATION TO RELEASE HEALTH INFORMATION

I, ______________________, Social Security # ______________, authorize the Seafarers Health and Benefits Plan ("Plan") to disclose the following protected health information:

☐ Pre-employment Physicals ☐ Claims Records/Claims History

Note: you must check one or both as this is what the Plan maintains.

I give the Plan permission to disclose this information to the following person or entity:

RECORDS DEPOSITION SERVICE, INC.
PO BOX 5054
SOUTHFIELD, MI 48086-5054

P 248.357.3330 F 248.357.3337

I am giving my permission to disclose the information listed above for the following reason(s): (for example: for a lawsuit, for employment purposes, or to help process my health claims)

FOR DISCOVERY BEFORE TRIAL
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I understand that I have the right to revoke this Authorization at any time. I must revoke in writing, either by a letter addressed to the Plan's Privacy Officer, 5201 Auth Way, Camp Springs, MD 20746, or by using the Plan's Revocation Form. Copies of the Revocation Form are available from the Plan's Privacy Officer. I understand that if I revoke this Authorization (or refuse at any time to sign an authorization to release my protected health information) it will not effect my eligibility for benefits from the Plan.

This Authorization shall remain in effect for ____________ month(s). The maximum period of time for this authorization to be in effect is one (1) year from the date listed below.

______________________________ ______________________________
Signature Date

____
Print name