

**AUTHORIZATION FOR RELEASE
OF PROTECTED HEALTH INFORMATION**

I authorize the use and disclosure of my protected health information as described below.

My protected health information is individually identifiable health information, including demographic information, collected from me or created or received by a health care provider, a health plan, my employer, or a health care clearinghouse and that relates to: (i) my past, present or future physical or mental health condition; (ii) the provision of health care to me; or (iii) the past, present, or future payment for the provision of health care to me (collectively "PHI").

The Fire and Police Retiree Health Care Fund, San Antonio ("HF"), provides health care benefits to me under the authority of legislation promulgated by the Texas Legislature (Article 6243q). The HF maintains PHI on me to assist in providing claims processing for health insurance coverage under the HF Plan Document. The HF has engaged WEB-TPA as a third party Administrator to assist the HF in processing claims under the HF Plan Document.

I _____, (plan participant) authorize the following
First Name Last Name
individual or person(s) to receive my PHI to assist the processing of my claims:

1. First Name: _____	Last Name: _____
Date of Birth: _____ <small>mm/dd/yyyy</small>	Relationship to health plan participant (if any): Insurance Representative- San Antonio Professional Firefighters <small>Spouse, Parent, Child, Brother, Sister, Representative</small>

2. First Name: _____	Last Name: _____
Date of Birth: _____ <small>mm/dd/yyyy</small>	Relationship to health plan participant (if any): _____ <small>Spouse, Parent, Child, Brother, Sister, Representative</small>

3. First Name: _____	Last Name: _____
Date of Birth: _____ <small>mm/dd/yyyy</small>	Relationship to health plan participant (if any): _____ <small>Spouse, Parent, Child, Brother, Sister, Representative</small>

4. First Name: _____	Last Name: _____
Date of Birth: _____ <small>mm/dd/yyyy</small>	Relationship to health plan participant (if any): _____ <small>Spouse, Parent, Child, Brother, Sister, Representative</small>

5. First Name: _____	Last Name: _____
Date of Birth: _____ <small>mm/dd/yyyy</small>	Relationship to health plan participant (if any): _____ <small>Spouse, Parent, Child, Brother, Sister, Representative</small>
"Authorized Parties, collectively"	

The PHI that may be used and disclosed is PHI relevant to that person's involvement in my care or payment related to my care. I acknowledge and give consent to HF to provide such individuals access to restrictive passwords/codes to access PHI in the medical records of HF and WEB-TPA. Access to such passwords for internet-based PHI records enables the user to all PHI. I hereby release HF and WEB-TPA from any liability or responsibility for unauthorized access by third parties that may gain access to such passwords/codes through Authorized Parties.

I understand that I may revoke this authorization at any time by sending a written notification to the HF, and this revocation will be effective for future uses and disclosures of PHI. However, I further understand this revocation will not be effective for information that HF or WEB-TPA has already used or disclosed relying on this authorization.

This authorization expires upon receipt of a written notification to revoke the authorization.

Group Number: 37FP	Member ID: _____ <small>Look on Your ID Card</small>
Plan Participant's Name: _____ <small>Print First Name</small>	_____ <small>Print Last Name</small>
Signature of Plan Participant: _____ <small>Please Sign In Ink</small>	

This authorization expires upon receipt of a written notification to revoke the authorization.

Please mail or fax this form to: Fire and Police Retiree Health Care Fund, San Antonio
300 Convent St., Suite 2500
San Antonio, Texas 78205
Fax: 210-212-4035