KINGSTON TRUST FUND
HIPAA MEDICAL RELEASE AND AUTHORIZATION

AUTHORIZATION: I authorize the release of Protected Health Information (PHI) by any health care facility, physician, surgeon, therapist, or insurance company to The Kingston Trust Fund Plan, its agents or employees, all information pertaining to me or any covered dependent, regarding past, present or future medical or mental conditions, any examination or treatment including treatment for alcohol abuse, substance abuse, behavioral disorders, AIDS, ARC (Aids Related Complex), and to any illness, injury, or condition that I or my dependent or spouse have had at any time in the past or in the future up until the expiration of this Authorization and/or coverage.

I understand this information may be collected for determining my eligibility for benefits, payment of claims, and to carry out TPO activities (Treatment, Payment, and Operations) as defined by the plan and under HIPAA.

This authorization is valid as long as I am covered by this Plan or until changed in writing. A photocopy, facsimile, or electronic copy of this Authorization is as valid as the original. I understand that I have the right to revoke this authorization, in writing, at any time. Such revocation must be made in writing. I understand that any issues related to HIPAA, HIPAA Compliance, or Claims Appeals or the revocation of this release is to be addressed to the Compliance Office. The contact may be made by mail to Compliance Office at 416 Creekstone Ridge, Woodstock, GA, 30188. The Compliance Office can be reached by phone at (844) 583-3863 x2 or by fax at (770) 874-1097.

I also understand that I have the right to have a representative deal on my behalf with respect to benefits, claims, or any issues related to this Plan. I hereby authorize the following individual to receive any such information or to act on my behalf as an authorized representative under HIPAA rules. My authorized representative is entitled to receive a copy of this form.

I understand that the dissemination and handling of confidential protected health information (PHI) will be in accordance with the HIPAA Privacy Rules under this Plan.

_____	_____	_____
Patient Name (Please Print)	Signature	Date
_____		_____
Address		Phone

DESIGNATED HIPAA REPRESENTATIVE (Complete the following as desired or leave blank.) If no representative is named, any dealings must be done directly with the patient/member.)

[ ] My Spouse (Name) _____ [ ] Other (Name): _____

_____	_____	_____
Spouse's Name (Please Print)	Signature	Date
_____	_____	_____
Dependent (Over 18) (Please Print)	Signature	Date
_____	_____	_____
Dependent (Over 18) (Please Print)	Signature	Date