Transport Workers Union – MTA Health & Welfare Trust
Authorization to Disclose Health Information

Name: _____
SS No.: _____
Payroll No.: _____
Address: _____
Phone No.: _____

I authorize the use or disclosure of the above named member's personal and health information as described below:

- ☐ Any and all records in your possession including mental health, HIV and /or substance abuse records. (Cross out any item you do not authorize to be released)
- ☐ Records regarding treatment for the following condition or injury _____ on or about _____
- ☐ Records covering the period of time _____ to _____
- ☐ Other (Please specify and include dates) _____ _____

This information may be disclosed to, and used by, the following individuals or organizations:

Name: _____
Address: _____

Name: _____
Address: _____

This information is being disclosed for the following purpose(s):
_____

I understand that I have the right to revoke this authorization at any time. I understand that in order to revoke this authorization, I must do so in writing and sent my written revocation t. I understand that the revocation will not apply to information that has already been released in response to the authorization. I understand that the revocation will not apply when the provided it with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire within thirty (30) months of the signature date.
I understand that I do not have to sign the authorization.
I understand that once the information is disclosed pursuant to this authorization, it may be redisclosed by the recipient and the information may not be protected by federal privacy regulations.

Signature of Member/Legal Representative: _____ Date_____
If signed by Legal Representative, relationship to Member: _____
If signed by legal representative, please provide representative documentation as required by state law, i.e. Power of Attorney, Health Care Surrogate, Living Will or Guardianship papers.

Transport Workers Union Metropolitan Transit Authority Health & Welfare Trust privacy pledge is to protect our members' personal information as if it were our own.

Transport Workers Union – MTA Health & Welfare Trust
General Power of Attorney

STATE of Texas

County of _____ KNOW ALL MEN BY THESE PRESENT:

That I, _____of the County of _____ and State of Texas do hereby constitute and appoint _____ of _____ County, Texas to be my duly and lawfully appointed attorney in fact granting unto said attorney in fact the full power and authority to do and perform any and all acts and/or things necessary or requisite to be done in furtherance of my interest, whether said acts involve medical/insurance affairs granting unto my attorney in fact a medical power of attorney permitting said attorney in fact as fully and for all intents and purposes as I might do if I were personally present. Said attorney in fact is empowered to use their sole discretion in handling matters relating to my interest.

This power of attorney will supersede my disability to the fullest extent possible for the laws of the State of Texas.

Witness my hand this _____ day of _____ 20 ____.

_____ _____

_____

Acknowledgement

STATE OF TEXAS

COUNTY OF _____

BEFORE ME, the undersigned authority, on this day personally appeared

_____ known to me to be the person whose name is subscribed to the foregoing document to acknowledge to me that (s)he executed the same for the purpose and consideration therein expressed.

GIVEN under my hand and seal of this office the _____ day of _____, 20 _____.

_____ Notary
Public in and for
The State of Texas