THIRD-PARTY AUTHORIZATION FORM

Plan: RIVERSIDE SHERIFFS' ASSOCIATION BENEFIT TRUST

Individual: _____
Member Name

Third Party: _____
Authorized Person's Name Relationship Date of Birth

The individual identified above is, or may be, eligible for benefits under the Plan. The individual wishes to have the third-party identified above assist him or her in dealing with the Plan.

Therefore, the individual hereby authorizes the Plan to disclose protected health information relating to the individual to the third-party respecting the following services:

Please list the specific information to be released. If you are authorizing the third party to have access to all information, please state: **Blanket Authorization.**

_____

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_____

Please list specific name or names of carriers. If you are authorizing the third party to have access to all carriers, please state: **Blanket Authorization.**

_____

_____

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Authorization shall remain in effect until status between the individual and third party has changed (i.e. divorce), but can be revoked by the individual in writing at any time.

_____ _____
Date Signature of Individual

Mail or Fax this Form to:
Riverside Sheriffs' Association Benefit Trust
21800 Cactus Avenue
Riverside, CA 92518
Phone: (951) 653-8014
Fax: (951) 653-9204