HIPAA Release of information
AUTHORIZATION FORM

I, _____ hereby authorize any and all healthcare insurer or affiliate the RETA Trust (including but not limited to Blue Shield and Catapult Health), to release to the Roman Catholic Bishop of Monterey or Diocese of Monterey Parish & School Operating Corporation ("Diocese of Monterey:") my personal health information maintained by Reta Trust limited as follows: 1. my name 2. whether or not I have completed the wellness questionnaire and 3. whether or not I have provided my biometric information to the Reta Trust. The authorization is given for the purpose of ensuring that I receive the wellness insurance rates from my employer (or my spouse or parent's employer).

I understand that any personal health information or other information released to the organization identified above may be subject to re-disclosure by such person/organization and may no longer be protected by applicable federal and state privacy laws.

This authorization is valid from the date of my signature below and shall expire the date my coverage ends with the Reta Trust.

I understand that I have a right to revoke this authorization by providing written notice to Stefanie Olsen (solsen@dioceseofmonterey.org). However, this authorization may not be revoked if the Diocese of Monterey employees or agents have taken action on this authorization prior to receiving my written notice. I also understand that I have a right to have a copy of this authorization. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment or coverage of services at the non-wellness insurance rates.

Name of Member: _____

Signature of Member: _____

Date:_____

Work Location: _____