American Airlines

Authorization for Release of Protected Health Information

Instructions: You must complete all the information below. If incomplete, this authorization form will be returned to you. If you have any questions or need assistance completing this form, please use Chat in the American Airlines Benefits Service Center or call 888-860-6178.

Purpose: I authorize the American Airlines Health & Welfare Plan for Active Employees (the "Plan") to disclose the information listed below to the authorized person(s) named below.

Section A: Employee Information

Employee Name: _____ Employee Number: _____
First and Last Name

Section B: Release of Protected Health Information ("PHI")

Name of person whose PHI is being released: _____

Member ID Number of person whose PHI is being released (from the front of the insurance card): _____

Address: _____

_____

Telephone Number: _____

Purpose of Disclosure: Check one box

At my request

Other (e.g., respond to inquiries regarding my health benefits, appeal assistance):

_____

_____

_____

Section C: Recipient of Protected Health Information

Name of person or organization allowed to receive PHI _____

_____

Section D: Acknowledgment, Authorization and Signature

I understand that:

- I have the right to revoke this authorization at any time for future disclosures the American Airlines Health & Welfare Plan for Active Employees (the "Plan") may make, unless the Plan has taken action in reliance upon this authorization. I must revoke this

authorization in writing directly to the American Airlines Benefits Service Center at the address provided below.

- The Plan may not condition my treatment, payment, enrollment, or eligibility for benefits upon whether I sign this authorization.
- Once my information has been disclosed, as permitted under this authorization, it may no longer be protected under the federal privacy regulations of the Health Insurance Portability and Accountability Act ("HIPAA"), so there is a possibility that the party to whom my information is being disclosed may re-disclose the information.

Unless revoked, this authorization is valid from the date of my signature until the date I am not longer covered by the Plan or until I revoke this authorization.

I authorize the use or disclosure of the PHI as indicated above:

Signature: _____

Date Signed: _____

If you are a personal representative, such as a Legal Guardian or agent acting under a Power of Attorney, you may be able to sign on behalf of the Member if the supporting paperwork has the required regulatory language. Complete the following and attach documentation (if applicable) supporting such personal representation and the Privacy Officer, or her designee, will determine whether it is sufficient to grant authorization.

Personal Representative's Name: _____

Relationship to Member or Authority to act as Personal Representative: _____

_____

_____

Please keep a copy of this document for your records and mail the completed Authorization to:

American Airlines Benefits Service Center
P.O. Box 564103
Charlotte, NC 28256-4103