The McClatchy Company
Authorization to Disclose Personal & Health Information

You May Refuse to Sign This Authorization

This form is used to authorize The McClatchy Company Comprehensive Welfare Benefit and Cafeteria Plan ("Plan") to release personal and health information for the purpose stated below.

Section A: Information to be Disclosed

This authorization is for release of information related to the (check only one box):

- ❑ Medical Plan: (name)_____
- ❑ Dental Plan: (name)_____
- ❑ Vision Plan: (Name)_____

The personal and health information to be released is related to (check only one box):

- ❑ Payment, billing and/or claims information
- ❑ Medical care and treatment

Section B: Personal Information

This authorization relates to the personal and health information of the following individual:

Name: _____ ID#:_____

Street Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____ Date of Birth: _____

Section C: Disclosure and Use of Personal and Health Information

Personal and Health Information to be Disclosed: The specific personal and health information you are authorizing the Plan to disclose includes the following (e.g., all information related to a certain claim or EOB) (if necessary, attach additional sheets):

_____

_____

_____

Purposes of this Authorization: By signing this form, you authorize the use of your personal and health information by a third party for the following purposes (e.g., for assistance with obtaining payment) (if necessary, attach additional sheets):

_____

_____

_____

Section D: Persons or Entities Authorized to Receive and Use Personal and Health Information

The persons and/or organizations to whom you are authorizing the Plan to disclose the personal and health information described in section C are:

1)Name: _____ 2) Name: _____

Section E: Expiration and Revocation

This Authorization for the release of your personal and health Information may be revoked or withdrawn at any time except to the extent that action has been taken in reliance on this authorization. Requests for revocation must be made in writing.

Expiration: This authorization will expire (specify one):

- ❑ On _____/_____/_____ One year from the date indicated in Section F below. Note: If this authorization is for the release of the personal and health information of a minor, the expiration date cannot exceed the 18th birthday of the minor.

Section F: Signature – You May Refuse to Sign this Authorization

No Conditions: This authorization is voluntary. We will not condition our payment activities in connection with your claims, your enrollment in our health plan or your eligibility for benefits on your giving this authorization.

I have had full opportunity to read and consider the contents of this authorization. I understand that, by signing below, I am authorizing the Plan to use and/or disclose the personal and health information as specified on this form.

I understand that if the persons or organizations I authorize to receive and/or use the personal and health information described in this form are not health plans, covered health care providers or health care clearinghouses subject to federal health information privacy laws, they may further disclose the personal and health information and it may no longer be protected by federal health information privacy laws.

Signature: _____ Date: _____

Print Name: _____

Person or Entity Authorizing Disclosure of Information: If you are signing on behalf of the member, please indicate your relationship to the member and provide copies of verification of your legal right to authorize the disclosure of the member's personal health information.

- ❑ Parent or guardian of minor patient (to the extent that the minor could not have consented to the care)
- ❑ Court appointed guardian, legal conservator, legal representative or an individual with Power of Attorney to disclose
- ❑ Durable Power of Attorney for Health Care
- ❑ Beneficiary or personal representative of deceased patient
- ❑ Spouse or person financially responsible

You will receive a copy of this authorization after you sign it. A copy of this authorization shall be considered as effective as valid as the original. Additionally, you may inspect or copy the personal and health information to be used or disclosed by contacting your Human Resources Department.