

AUTHORIZATION FOR RELEASE OF INFORMATION

MEDICAL PLAN CLAIM ADMINISTRATOR NAME

To the Medical Plan Claim Administrator Named Above, (the "Claim Administrator")

I hereby authorize the below designated individuals, who are duly designated representatives of the Communications Workers of America (CWA) to act on my behalf in connection with the benefit issue as described below:

PLAN: Mental Health / Employee Assistance Benefits

Point of Service Supplemental Transplant Assistance Plan Short-term disability

Medical Assistance Plan Health Maintenance Organization Concorde

Long-term / Retirement Disability Family & Medical Leave Act Other

I authorize the Claim Administrator to release to the below designated CWA representative(s) and the Plan Holder, BellSouth Telecommunications, Inc., or its representative, (BellSouth) any and all information and documentation requested by them which specifically relates to the benefit issue described above, including but not limited to medical or clinical information and documentation relating to the request to the extent allowed by state law. The below designated individuals agree to use this information and documentation solely for the processing the request noted above, and agree that no information and documentation relating to this request will be released by them to any other party without my express written consent.

I hereby release the Claim Administrator from any claim that I might have against the Claim Administrator for releasing such information and documentation to the below designated CWA Representative(s) and/or BellSouth.

I understand that both I and the below designated individuals may obtain a copy of this signed authorization form from the Claim Administrator. These authorizations shall be valid for the duration of the claim, or until the termination of the affected plan, whichever is sooner.

Designated/Approved CWA Representative(s) Name(s):

_____ Date: _____

_____ Date: _____
Employee Signature (Necessary for the release of either employee or dependent information)

_____ Date: _____

Employee Social Security Number: _____

Spouse signature or Signature of Custodial Parent (if dependent involved)

_____ Date: _____