NFL PLAYER BENEFITS

NFL Player Benefits Office
200 St. Paul Street, Suite 2420
Baltimore, Maryland 21202
Phone 800.638.3186
Fax 410.783.0041

AUTHORIZATION FOR RELEASE OF PLAYER RECORDS AND INFORMATION

TO	NFL Player Benefits Office 200 Saint Paul Street, Suite 2420 Baltimore, MD 21202

RE	Player Name:	
	DOB:	Last 4 SSN:

I authorize and request the disclosure of full and complete medical information and other Plan records for the purpose of review and evaluation in connection with a legal claim.

I expressly request disclosure of all files, meaning every page in my file, concerning any claim(s) or appeal(s) for benefits including, but not limited to, applications, claim forms, medical records generated in the course of my claim for benefits and any records submitted by me, independent evaluations, and determination letters that are maintained by the following employee benefit plans (individually, a "Plan," collectively, the "Plans"):

_____ 88 Plan

_____ NFL Player Disability & Survivor Benefit Plan

_____ Gene Upshaw NFL Player Health Reimbursement Account Plan

_____ Bert Bell/Pete Rozelle NFL Player Retirement Plan (disability benefits)

(Check all that apply)

The Plan(s) are authorized to release the above-referenced files to the following individuals:

[name] [address] [email]	[name] [address] [email]

I understand the following:

a. I have a right to revoke this Authorization in writing at any time, except to the extent information has been released in reliance upon this Authorization. I must revoke this Authorization in writing directly to the Plan(s).

b. My eligibility for, enrollment in, or payment of benefits from the Plan(s) cannot be conditioned on the signing of this Authorization.

c. 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 of 1996 ("HIPAA"), so there is a possibility that the party to whom my information is being disclosed may re-disclose the information.

This Authorization is limited to existing records only, and is not to be construed as an Authorization permitting the Plan to prepare written reports or orally discuss, disclose or render any opinions regarding any records, health information or prognosis relating to the above-named Player with the attorneys who are requesting the records, or anyone acting on behalf of those attorneys.

A facsimile, copy, or e-copy of this Authorization shall have the same effect as an original hardcopy. This Authorization shall be in force and effect for a period of one year after the date of my signature below, at which time this Authorization expires.

PLAYER

_____	_____	_____
Signature of Player	Printed Name	Date

LEGALLY AUTHORIZED REPRESENTATIVE

This Authorization may be completed by a Player's legally authorized representative, such as a legal guardian or an individual with the Player's power of attorney.

By signing below, I represent that I have authority under state law to act on the Player's behalf and will submit a copy of the applicable documentation, e.g., power of attorney or court order, with this Authorization.

_____	_____	_____
Signature of Legally Authorized Representative	Printed Name	Date

NOTARY CERTIFICATE

STATE OF _____

COUNTY OF_____

THE FOREGOING AUTHORIZATION was sworn to and subscribed before me, an officer/notary duly authorized in the State and County aforesaid, to take acknowledgments, this _____ day of _____, 20___, by _____, who is personally known to me OR has produced _____ as identification, who did take an oath, and who executed the within documents, and who acknowledged the within document to be freely and voluntarily executed for the purposes therein recited.

_____	_____
Signature of Notary	Print, type or stamp commissioned name of Notary