MphasiS Employee Health and Welfare Benefit Plan

AUTHORIZATION FOR RELEASE OF INFORMATION

Name: _____ **SSNO:** _____

This authorization is provided in accordance with the privacy standards for "Protected Health Information" ("PHI") under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). I hereby specifically authorize the use or disclosure of PHI applicable to my participation under the MphasiS Employee Health and Welfare Benefit Plan, in accordance with the instructions provided below:

Persons/Organizations Authorized to Receive PHI:

Name: _____ Name: _____
SSNO.: _____ SSNO.: _____
Relationship: _____ Relationship:
_____

Description of Information to be Used or Disclosed (including dates):

_____
_____
_____

Purpose of the Use or Disclosure:

_____
_____

Expiration of Authorization: This authorization will expire (check one item):
_____ (Specific Date: _____), or
_____ Upon revocation by subsequent written direction.

I understand that I have the following rights with regard to this authorization:

- I may revoke this authorization at any time, by completing the "Revocation of Authorization For Release of Information" form, and that such revocation will only be effective after it is received and processed by the Plan Sponsor, Scientific Drilling International, Inc., or its affiliate.
- I am not required to complete this form in order to receive benefits under the Plan.
- The information that is used or disclosed pursuant to this authorization is no longer under the control of the Plan and may be re-disclosed by the recipient, which disclosure is outside the control of the Plan or the Plan Sponsor.
- I am entitled to receive, upon request, a copy of this form.

_____ _____
Date **Signature of Participant**