PLUMBERS AND STEAMFITTERS LOCAL UNION NO. 33 HEALTH & WELFARE FUND
AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

The Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule does not allow the Plumbers and Steamfitters Local Union No. 33 Health & Welfare Fund to give out your personal protected health information to anyone without your permission, including your husband, wife, child, siblings, or lawyer. You will need to complete and return this form to the Fund to allow the Fund to release your information to other people on your behalf. If you do not want your Protected Health Information (PHI) to be released to another person, do not complete and return this form to the Fund.

I authorize the Plumbers & Steamfitters Local Union No. 33 Health & Welfare Fund to use or disclose my protected health information as specified below.

1. PATIENT INFORMATION

The patient is the individual who the information (such as medical claims and enrollment) is about.

Name of Patient_______________________________
(please print)

Social Security Number_________________________

2. PARTICIPANT/RETIREE INFORMATION

Fill out the Participant/Retiree Information if the Patient and the Participant/Retiree are not the same person.

Name of Participant/Retiree_______________________________
(please print)

Social Security Number_______________________________

3. PERSON AUTHORIZED TO RECEIVE MY PERSONAL HEALTH INFORMATION.

Fill out the information about the person(s) to whom you want your information disclosed.

˘ My husband/wife:____
(please print your husband or wife¢s name)

˘ Other Individual Who Can Receive PHI:_______________________________

Address:____

Phone Number:____

˘ Other Individual Who Can Receive PHI:_______________________________

Address:____

Phone Number:____

4. RESTRICTIONS ON INFORMATION I WANT RELEASED:

˘ I would like all of my information to be released.

˘ I would like all except the following information to be released:

_______ Medical Records
_______ Physical Therapy Records
_______ Prescription Records
_______ Explanation of Benefits
_______ Laboratory Reports
_______ Records Relating to Alcohol, Drug or Other Substance Abuse
_______ Records Relating to Psychiatric or Mental Health Disorders

˘ Other:____

5. THE PURPOSE OF THIS AUTHORIZATION IS_______________________________

You do not need to state a purpose. If you do not state a purpose the Fund will consider the authorization at your request.

6. EXPIRATION DATE OR EVENT

Unless you tell the Fund otherwise, the Fund will consider this authorization valid until you, or your personal representative, revoke this authorization.

If you do want this authorization to expire, please indicate your expiration date below:

˘ When I am no longer enrolled under this health plan.

˘ Other:_______________________________

7. PATIENT'S ACKNOWLEDGMENT AND SIGNATURE *(read the acknowledgement and sign and date this form)*

I acknowledge that I have read and understand what information is covered by this authorization, and that I understand: (1) that I may revoke this authorization at any time; (2) that my revocation of this authorization may not cover any disclosures that were already made in reliance on this authorization before the Fund receives my written revocation; (3) that I do not give up any rights to treatment, payment, enrollment, or eligibility for benefits based on whether I sign or refuse to sign this form; and (4) that once my information has been disclosed according to this authorization, the information may no longer be protected, and the recipient named in item 3 above may be able to further disclose the information.

I understand that my PHI may include, but is not limited to the following: legal documents, eligibility or enrollment information, demographics, medical records, emergency care records, billing statements, Explanation of Benefits, diagnostic imagine reports, transcribed hospital reports, laboratory reports, dental records, pathology reports, physical therapy records, hospital records (including nursing records and progress notes), claim status, claim information, confirmation or denial that treatment has occurred, treatment information, information on my physical or mental condition, and any personal or medical information related to the purpose of this authorization. I further understand that my PHI may include information related to any of the following: genetic testing, mental health (excluding psychotherapy notes), HIV/AIDS, prescription medication, pregnancy, maternity, organ transplants, and chemical dependency (including alcohol and drug treatment).

Patientøs signature____ Date signed______________________________________

REPORTING OF PERSONAL REPRESENTATIVE INFORMATION

*Complete the Personal Representative Information section **ONLY** if "The Patient" has already legally designated someone to act as their Personal Representative in medical benefits-related matters, such as Power of Attorney, Medical Power of Attorney, or some other legal authority to act on their behalf.*

Please attach a copy of the legal documentation that provides the Personal Representative with the authority.

1. PATIENT INFORMATION
The patient is the individual who the information (such as medical claims and enrollment) is about.

Name of Patient____________________________
(please print)

Social Security Number________________________

2. PARTICIPANT/RETIREE INFORMATION
Fill out the Participant/Retiree Information if the and the Participant/Retiree are not the same person.

Name of Participant/Retiree__________________________________
(please print)

Social Security Number_____________________________________

The person named below has been designated to act legally on behalf of "The Patient" in matters concerning the group health plan. "The Patient's" Protected Health Information may be disclosed to this person. Attached is a copy of a document that shows this person is legally permitted to act as the Personal Representative of "The Patient."

Name of Personal Representative______________________________ Relationship________________________________

Address of Personal Representative____

____

Phone Number of Personal Representative:____

Signature of Personal Representative:____Date Signed:_________________