Authorization for Release of Protected Health Information

Participant

I, **(Print Name)**_____, (**Social Security #**)_____, a participant in the Health and Benefit Trust Fund of the I.U.O.E. Local 94-94A-94B, AFL-CIO (the "Plan"), authorize the Plan, its agents and its business associates to disclose any and all health information about me, past, present and future (including eligibility, claims, and payment information), except information contained in psychotherapy notes, to the following persons as they so request.

If I only want specific information disclosed, I will check this box ☐ and attach a page detailing the health information I am authorizing for disclosure. I am authorizing disclosure of my health information to:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I understand that this authorization will be enforced unless I revoke it, or my Fund coverage terminates, whichever one of these dates is the earlier thereof. I understand that I have the right to revoke it at any time, except to the extent that it has already been relied upon. I understand that if I decide to revoke this authorization, I must give notice of my decision in writing and send it to the Plan at 331-337 West 44th Street, New York, NY 10036. I understand if I wish to revoke and or make changes to this authorization I must complete an Authorization for Release of Protected Health Information form.

I understand that any such revocation shall not apply to any use or disclosure of my protected health information which is specifically allowed without authorization by HIPAA and no action relating to this authorization shall be construed as creating any restriction on the uses and disclosures that HIPAA allows without my authorization. I also understand that health information disclosed pursuant to this authorization may be redisclosed by the persons I have authorized above and will no longer be protected by HIPAA's Privacy Rule, and that the Plan cannot prevent or protect such redisclosures. Finally, I understand that I am not required to sign this form to receive my health care benefits (eligibility, enrollment, treatment or payment), and that any information disclosed pursuant to this authorization is being made at my request. You may provide a more specific description of each purpose of the requested use or disclosure on an attached page, if you so desire.

Signature of Participant:_____ Date Signed: _____

Spouse

I, **(Print Name)**_____, the **spouse** of the above named participant have read the above participant section and understand its terms. I authorize the Plan to disclose claims, payment, eligibility, and other related health information (except information contained in psychotherapy notes) about me to the following persons for the reasons stated and subject to the conditions listed in the Participant section above, at the request of such persons:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Signature of Spouse: _____ Date Signed: _____

Adult Dependent Child

I, **(Print Name)**_____, the **dependent child** over the age of 18 of the above named participant have read the above participant section and understand its terms. I authorize the Plan to disclose claims, payment, eligibility, and other related health information about me (except information contained in psychotherapy notes) to the following persons for the reasons stated and subject to the conditions listed in the Participant section above, at the request of such persons:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Signature of Child: _____ Date signed: _____

Upon request, the Plan will provide a copy of this signed authorization.

PLEASE NOTE THAT IF THE AUTHORIZATION IS SIGNED BY A PERSONAL REPRESENTATIVE OF THE INVOLVED INDIVIDUAL, A DESCRIPTION OF SUCH REPRESENTATIVE'S AUTHORITY TO ACT FOR THAT INDIVIDUAL MUST ALSO BE PROVIDED.