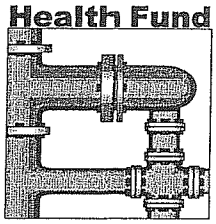

Connecticut Pipe Trades Health Fund
1155 Silas Deane Hwy
Wethersfield, CT 06109-4318
(860)571-9191 Fax (860)571-9221
www.connecticutpipetrades.com

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I hereby authorize the Connecticut Pipe Trades Health Fund ("Fund") and any of its parents, subsidiaries or other affiliates (including vendors) and their respective agents and subcontractors to disclose confidential information about the participant identified below. I UNDERSTAND THAT THIS AUTHORIZATION IS VOLUNTARY.

Participant Information

Name: _____

Address: _____

Social Security No. _____

Date of Birth: _____

Phone No. _____

I authorize the Individuals or Class of Individuals identified below to receive confidential information pertaining to the participant named above.

Individual or Class of Individuals Authorized to receive confidential health information pertaining to the Participant named above:

_____

Purpose for the Release or Disclosure of Information

___ Disclosures to be made at the request of the Participant (only when Participant initiates the authorization form)

___ Other purpose, i.e., To discuss my benefits with the Fund and TPA so that I better understand my benefits _____

___ Disclosures to made between _____ and _____
Month/Day/Year Month/Day/Year

Specific and Meaningful Description of the Information to be Released or Disclosed: (Check all that are appropriate)

___ Application or enrollment information

___ Claim records

___ Claim, billing and EOB information relating to the following services or claim: (specify date of service and/or medical condition)

_____

___ Others: (Please Specify: _____)

IMPORTANT: Your signature below means that you understand and agree to the following:

- Information disclosed under this authorization may be re-disclosed by the recipient and no longer protected by federal privacy regulations.

- You are entitled to receive a copy of this authorization from the Fund if you ask for it by writing to the address listed at the bottom of the page.

- Your treatment, ability to enroll in the Fund, eligibility for health plan benefits and/or payment for services will not be affected if you do not sign this form. (However, without your signature, your request to release the information described above to a third party will not be honored).

- If the Fund receives requests for copies of claims or other information from the individual or class of individuals you have authorized to receive your confidential information, we may charge a reasonable fee (Except where prohibited by law) to defray our copying and mailing costs.

- This protected health information provided under this authorization may include diagnosis and treatment information, including information pertaining to chronic diseases, behavioral health conditions, alcohol or substance abuse, communicable diseases, including HIV/AIDS and or genetic marker information. These records will be included in the information we will make available to the individual or class of individuals designated above.

- Unless revoked earlier, this authorization will expire one year from the date you sign this authorization. If you sign this form, you may revoke the authorization at any time by notifying the Fund Administrator in writing at the address below. Your revocation is only effective after it is received and logged by the Fund Administrator. Revoking this authorization will not have any effect on actions taken by the Fund in reliance on this authorization prior to receiving such revocation.

Signature of Participant or Personal Representative

Signature of Participant: _____

Printed name of Participant: _____

Date: _____

If signed by a Personal Representative:

Signature of Personal Representative: _____

Printed name of Personal Representative: _____

If a Personal Representative executes this form, that Representative warrants that he or she has authority to sign the form on the basis of:

_____

Should a Participant's Personal Representative (other than the parent of an unemancipated minor child) sign this authorization, you must furnish to the Fund a copy of the health care power of attorney, or other relevant document designating you as the Personal Representative in order to verify your authority to act for the Participant.

Return this completed form to:

Connecticut Pipe Trades Health Fund
1155 Silas Deane Hwy.
Wethersfield, CT 06109-4318
Tel: (860) 571-9191