NEW ORLEANS EMPLOYERS - INTERNATIONAL LONGSHOREMEN'S ASSOCIATION, AFL-CIO, WELFARE PLAN ("PLAN")

AUTHORIZATION FOR USE AND/OR DISCLOSURE OF HEALTH INFORMATION

I, ______________________________, hereby authorize the Plan to use or disclose my health information as described in this authorization.

(1) Specific description of the health information I authorize to be used or disclosed:

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(2) Specific person(s) or class of persons to whom the Plan may disclose such health information for their use:

____

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(3) Purpose of the request (either check "At my request" or state the reason):

At my request, **or** for the reasons stated below:

____

____

(4) I understand that this authorization will terminate when I am no longer covered by the Plan unless I state below an earlier termination time or event, or at any time that I file a written revocation:

____

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(5) *Right to revoke:* I understand that I have the right to revoke this authorization at any time by written notification to the Plan at the address listed below. I also understand that a revocation is effective only after it is received and logged by the Plan. I understand that any use or disclosure made under this authorization before it is revoked will not be affected by my revocation.

(6) I understand that the Plan will not condition treatment, payment, enrollment or eligibility for benefits on my providing this authorization.

(7) I understand that after health information is disclosed under this authorization, federal privacy rules may no longer protect it, and the recipient might disclose it again.

(8) I understand that I am entitled to a copy of this signed authorization.

____

Signature of Participant/Beneficiary or Personal Representative

Date:
Print Name: ______________________________
Address: ______________________________
____
Telephone Number: ______________________
Social Security Number: __________________

If signed by a Personal Representative, the Personal Representative warrants that s/he is authorized to sign on behalf of the Participant/Beneficiary based on the following authority:

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____

AUTHORIZATION MUST BE FILED WITH THE PLAN EITHER AT THE ADDRESS LISTED BELOW IF COMPLETED OR AS STATED BELOW:

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____

OR

Administrator, Fund Office
147 Carondelet Street,
Suite 300
New Orleans, Louisiana 70130-2501
(504) 525-0309