AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I hereby authorize the Iron Workers District Council Fund of Western New York and Vicinity Supplemental Fund to disclose my individually identified health information (Protected Health Information or PHI) as described below. I understand that after the information is disclosed, it may no longer be protected by Federal Privacy Regulations and the recipient might re-disclose it.

Section I: Indicate Participant whose information is to be released:

Name: _____ ID number: IWDC_____ DOB ____/ _____/ _____

Section II: I authorize disclosure of health information to the following:

Name(s) and Address of persons/organizations authorized to receive the information:
1._____

2._____

Section III: Purpose of Request (i.e., personal use, school, attorney, future medical care, "at the request of the individual", or other):

If you would like the Fund Office to disclose and discuss the following information to the persons/organizations identified above, **please initial applicable items:**

1. Enrollment, disenrollment, eligibility, and dependent information: 1._____
2. Amount of contributions needed for coverage: 2._____
3. Benefits available and/or received under the Fund: 3._____
4. Claim payment history and status of claims and/or appeals: 4._____
5. HIV / AIDS related information: 5._____
6. Mental Health Information and/or records: (other then Psychotherapy notes.) 6._____
7. Drug/Alcohol diagnosis and treatment: 7._____
8. Pregnancy and family planning: 8._____
9. There are no restrictions of on the type of information that may be disclosed to the person(s) /organization(s) designated above: 9._____
10. Only information related to (specify): 10._____

The participant/patient or the participant's/patient's representative must read the following statement:

1. I understand that this authorization is voluntary and that I have the right to refuse to sign this authorization. I understand that I am entitled to receive a copy of this authorization;
2. I understand that I have the right to revoke this authorization at any time by contacting the Fund Office in writing. I understand that the revocation is only effective after it is received by the Fund Office and it will not effect any actions taken by the Fund Office based on the authorization and prior to receipt of the revocation.
3. I understand that this authorization will expire on _____ (Please provide specific date or specific event, such as loss of eligibility).
4. I understand that the person/organization authorized to receive the information may not treat it as confidential and may re-disclose it.
5. I understand that the Fund Office will not condition treatment, payment, enrollment, and/or benefits eligibility in my providing this authorization.

_____ ___ / ___ / 20___
Participant/Patient Signature Date

_____
Print your name

_____ ___ / ___ / 20___
Signature of Participant's/ patient personal representative(s) Date
(Form must be completed before signing)

_____ _____
Print Personal Representative's name Basis of Authority to act for Participant (i.e.: POA)
Include copies of document(s) establishing authority

*** See reverse side for Welfare (health insurance) HIPAA release form***