WISCONSIN ELECTRICAL EMPLOYEES BENEFIT FUNDS

2730 DAIRY DRIVE • SUITE 101 • MADISON, WI 53718 • PHONE (608) 276-9111 • (800) 422-2128
RECEIVING FAX (608) 276-9103 • HEALTH CLAIM FAX (608) 288-9095
SPONSORED BY: INTERNATIONAL BROTHERHOOD OF ELECTRICAL WORKERS
LOCAL UNIONS #14, 127, 158, 159, 388, 430, 577, 890
NATIONAL ELECTRICAL CONTRACTORS ASSOCIATION-WISCONSIN CHAPTER

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I, _____, hereby authorize the Wisconsin Electrical Employees Health and Welfare Plan (the "Plan") to disclose my health information as described in this authorization. This authorization shall also apply to the following designated business associate of the Plan to the extent the business associate maintains the information that is the subject of this authorization: _____ (Insert name of business associate authorized to release information pursuant to this authorization).

(1) *Specific person/organization (or class of persons) to whom the Plan is authorized to disclose the information:*

_____
_____
_____

(2) *Specific description of the information to be disclosed by the Plan:*

_____
_____
_____

(3) *Right to Revoke:* I understand that I have the right to revoke this authorization at any time by notifying the Plan in writing at 2730 Dairy Drive Suite 101, Madison WI 53718. I understand that the revocation is only effective after it is received by the Plan. I understand that any use or disclosure made prior to the revocation of this authorization will not be affected by the revocation.

(4) *Potential for Redisclosure:* I understand that after this information is disclosed, federal law might not protect it, and the recipient might redisclose it.

(5) *Right to Copy:* I understand that I am entitled to receive a copy of this authorization.

(6) *Expiration of Authorization:* This authorization will expire [choose and complete one]

☐ On the _____ day of _____, 20 _____.

☐ Upon the occurrence of the following event:

_____.

(OVER)

(7) *Voluntary:* I understand that I am under no obligation to sign this form. I acknowledge I am voluntarily signing this form to release my health information to the party I have designated.

(8) *Benefits Not Conditioned on Form:* I understand that the Plan may not condition enrollment in the Plan or eligibility for benefits on this authorization form unless the purpose of this authorization form is to allow the Plan to obtain information it needs to make an eligibility, enrollment or underwriting determination.

(9) *Purpose of Authorization:* I am requesting that my information be disclosed for the following purpose (individual can simply state "pursuant to individual authorization"):

_____.

(10) *Photocopy and Facsimile:* A photocopy or facsimile of this signed authorization form shall be considered as valid as an original signed copy.

I have had an opportunity to review and understand the contents of this form. By signing this form, I am confirming that it accurately reflects my wishes.

Date Individual Signature

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PERSONAL REPRESENTATIVE SECTION

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

☐ A power of attorney for health care purposes including the right to access protected health information, notarized by a notary public (copy attached).

☐ A court order of appointment of the person as the conservator or guardian of the individual (copy attached).

☐ An individual who is the parent of an unemancipated minor child may generally act as the child's personal representative (subject to state law exceptions).

☐ Other: _____.