HIPAA Authorization

Consent to Obtain Health Care Information

HIPAA is an acronym that stands for the Health Insurance Portability and Accountability Act, a US law designed to provide privacy standards to protect patients' medical records and other health information.

You must submit your completed **HIPAA AUTHORIZATION** to your physician and the Fund Office. This form gives your physician permission to share your health information with the Fund and permission for the Fund to use this information in determining your benefit.

Employee Name		Today's date	
Social Security number		Primary phone number	
Date of birth		Email address	
Home address	City	State	Zip code

I authorize the health care provider(s) named on this form to release to the Board of Trustees of the Electrical Workers Local 369 Benefit Fund, or their designated representative, the health care information pertaining to my claim for a Disability Benefit from the Plan.

I understand that:

- ☐ The purpose for obtaining this information is to assist the Board of Trustees of the Electrical Workers Local 369 Benefit Fund in determining my eligibility for a Disability Benefit from the Plan.
- ☐ I have the right to inspect the health care information released to the Board of Trustees of the Electrical Workers Local 369 Benefit Fund or their designated representative.
- ☐ The Board of Trustees of the Electrical Workers Local Union Benefit Fund cannot further disclose the health care information it obtains without my written consent, except as provided by state or federal law.
- ☐ This consent will remain in effect until _____ (expiration date or event). However, I may revoke my consent in writing at any time except to the extent that the Board of Trustees of the Electrical Workers Local 369 Benefit Fund or their designated representative or any of the above listed providers have already taken action in reliance on this consent.

Health care providers

Name			
Phone number			
Address	City	State	Zip code
Name			
Phone number			
Address	City	State	Zip code
Name			
Phone number			

Address	City	State	Zip code

Name

Phone number

Address	City	State	Zip code

Type of Information That May Be Obtained (check all that are applicable):

- ☐ Medical History, Examination, Reports
- ☐ Operation Reports
- ☐ Treatment or Tests
- ☐ X-ray Reports
- ☐ Alcohol and Drug Abuse Records
- ☐ Mental Health Treatment Records
- ☐ Laboratory Reports
- ☐ Prescriptions
- ☐ Consultations
- ☐ Hospital Records, including reports
- ☐ Copies of all other health care reports

By signing this form, I affirm that, to the best of my knowledge, the information I am providing is true and accurate. I am aware that the Plan provisions are provided in the Electrical Workers Local 369 Benefit Fund Plan Document. If there is a discrepancy between the wording here and the Plan Document, the language in the Plan Document governs. I acknowledge that the Trustees reserve right to interpret, amend, modify or terminate this Plan or any of the benefits at any time.

Employee signature **Date**

If you are completing this form and providing documentation as the legal representative of the employee, please complete the following.

Your Name

Relationship	Primary phone number

Representative signature Date