Electrical Workers Local 369 Benefit Fund

Authorization Form

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I _____ [*name of individual*] hereby authorize the use or disclosure of my health information as described in this authorization.

1. Specific person/organization (*or class of persons*) authorized to provide the information:

_____

_____

2. Specific person/organization (*or class of persons*) authorized to receive and use the information

_____

_____

3. Specific and meaningful description of the information:

Please describe the information you wish the Fund to disclose.

[*E.g., written, electronic and oral information related to eligibility for benefits for the time period commencing on _____ date and continuing through _____ date.*

E.g., written, electronic and oral information including claims, reports, and other documents related to claims for benefits for an injury or illness commencing on _____ date and continuing through _____ date.

E.g., written, electronic and oral information relating to payment or lack of payment of benefits to [name of health care provider] for services rendered on _____ date.]

_____

_____

4. Purpose of the request:

Please state the purpose of the request below. [*E.g., to discuss my benefits with the Fund and its TPA so that I can better understand my benefits.*] If you do not wish to state a purpose, please state, "At the request of the individual."

_____

_____

5. Right to Revoke: I understand that I have the right to revoke this authorization at any time by notifying the Fund in writing at Electrical Workers Local 369 Benefit Fund, 906 Minoma Avenue, Louisville, Kentucky 40217. I understand that the revocation is only effective after it is received and logged by the Fund. I understand that any use or disclosure made prior to the revocation under this authorization will not be affected by a revocation.

6. I understand that after this information is disclosed, federal law might not protect it and the recipient might disclose it again.

7. I understand that I am entitled to receive a copy of this authorization.

8. I understand that this authorization will expire on [*insert an expiration date or event, for example, one year*].

_____

_____

9. The Fund will not condition treatment, payment, enrollment or eligibilityfor health plan benefits on receipt of an authorization.

OR

The Fund may condition enrollment in the Fund or eligibility for health plan benefits on receipt of authorization prior to enrollment, if the authorization is sought for underwriting or risk rating determinations and does not relate to psychotherapy notes.

Signature of Individual _____ Date _____

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

[*This authorization reflects the requirements of 45 CFR § 164.508 (August 14, 2002).*]