HIPAA form for Participant (Policy Holder)

Authorization for Release of Health Information

Section A: Plan Participant Information

Please complete this form to all the Fund to discuss your private health information with authorized representative.

Pronouns	Participant's Name	Participant's Social Security #

Section B: Authorized Use and/OR Disclosure

Intended Use or Disclosure:

I understand that the Welfare Fund, Pursuant to new privacy laws, may not generally disclose my health information without my written authorization to my family members or other individuals that i may want to have access to my health information. For this reason, I authorize United Food & Commercial Workers Local 655 Welfare Fund to discuss and disclose my health information that is maintained by the Fund to the person(s) that I have named below.

I understand that I have the right to limit the information that the Fund releases under this authorization. For example, I may limit my Authorized Representative's access to information about a particular health care provider or a particular diagnosis/disease. Any such limitations must be described below in writing, I understand that by leaving this section blank, I am creating no limitations on disclosure.

Authorized Representative #1

Name	Relationship to You	Phone #

Address

Limitations on Disclosure

Authorized Representative #2

Name	Relationship to You	Phone #

Address

Limitations on Disclosure

Authorized Representative #3

Name	Relationship to You	Phone #

Address

Limitations on Disclosure

Continue

Section C: Expiration

This authorization to release information to my Authorized Representative will automatically expire upon a lapse of my enrollment in the plan for a period of two consecutive years.

Section D: Important Information Concerning Your rights

- ➔ You may revoke this Authorization at any time. However any revocation will not apply to the extent that we have already taken action in reliance upon your Authorization. Your request for revocation must be in writing. We will provide you with a revocation form at your request.
- ➔ We may not condition the provision of treatment, payment, enrollment in a health plan, or eligibility for benefits upon your signing this Authorization.
- ➔ Information used or disclosed pursuant to this Authorization may be subject to re disclosure by the recipient and may no longer be protected by Federal health information privacy laws.
- ➔ You are entitled to a signed copy of this Authorization.

Section E: Signature/Authorization of Policy Holder

I have had full opportunity to read and consider the content of this Authorization. I confirm that this authorization is at my request. I understand that, by signing this form, I am confirming my authorization that the health plan may use and/or disclose my personal health information to the person(s) named in Section B.

Signature: Date:

Please submit this form via one of the following:

(preferred) **1** Log in to your participant portal at **www.655hw.org** or scan the **QR code** below for quick access. Then, use the **"FORM UPLOAD"** feature to directly send your form to your welfare fund file.

2 Fax: 314.966.9848

3 Mail to:
UFCW LOCAL 655 WELFARE FUND
300 Weidman Road, Suite A
Ballwin, Missouri 63011