CHAUFFEURS, TEAMSTERS AND HELPERS LOCAL UNION NO. 301
I.B. OF T. Health and Welfare Fund and Pension Fund Trustees

36990 North Green Bay Road Waukegan, Illinois 60087 Medical Insurance Phone - (847) 623-3915

Teamsters Local 301 Health and Welfare Plan
PHI Authorization Form

Employee Name:		**Birth Date:**	
Address:			
City, State, Zip			
Home Phone No.:			
Social Security No:			
Spouse Name:		**Birth Date:**	
Spouse SSN:			

Whose protected health information is being authorized for disclosure? (check all that apply):

☐ Yourself ☐ Spouse ☐ Dependent Children

(Spouse and Dependent Children over 18 must sign this authorization on their own behalf)

If you are authorizing the disclosure of your dependent child's protected health information to another person (such as an aunt, uncle or attorney) you must provide the names, etc. of the dependents to whom this authorization applies on the lines below:

Dependent Child's Name	Relationship	Date of Birth	Social Security No

By signing this form, I authorize the Teamsters Local 301 Health and Welfare Plan's medical claims adjusters, customer service representatives and their business associates, as well as the organizations below to use and/or disclose health information (information that constitutes protected health information as defined in the Privacy Rule of the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996) in the manner described below. I understand that I am under no obligation to sign this form. The person(s) and/or organization(s) described below, who I am authorizing to use and/or disclose this information may not condition treatment, payment enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization, except as follows:

Teamsters Local 301's Health and Welfare Plan may condition the payment of a claim on this authorization if the purpose of this authorization is to allow the Plan to obtain the information it needs to make a claim payment determination and psychotherapy notes are not requested.

I have signed this form voluntarily to document my wishes regarding the use and/or disclosure of the health information described below.

1. ***Description of the Health Information that I authorize to be used and/or disclosed.*** The following is a description of the health information I authorize to be used and/or disclosed:

• All protected health information (PHI) maintained or used by the Fund or its business associates.

2. ***Persons/Organizations authorized to Use and/or Disclose the health information:*** I authorize the following person(s) and/or organization(s) (or classes of persons and/or organizations), including Teamsters Local 301's Health and Welfare Plan and their business associates, to use and/or disclose the health information described in section 1 of this form:

List Name(s) of authorized Persons:	
Relationship:	
List Name(s) of authorized Persons:	
Relationship:	

3. ***Persons/Organizations authorized to Receive and/or Use my health information:*** I authorize the following person(s) and/or organizations (or classes of persons and/or organizations), including Teamsters Local 301's Health and Welfare Plan and their business associates to receive my health information from the person(s) and/or organization(s) (or classes of persons and/or organizations) described in section 2 and to use or disclose such information for the purposes listed below in section 4 of this form. I understand that if the person(s) and/or organization(s) listed below are not health care providers, health plans or health care clearinghouses subject to federal privacy standards, the health information disclosed pursuant to this authorization may no longer be protected by the federal privacy standards and such person(s) and/or organization(s) may re-disclose my health information without obtaining my authorization.

List Name(s) of authorized Persons:	
Relationship:	
List Name(s) of authorized Persons:	
Relationship:	

4. ***Description of each purpose for the requested use and or disclosure:*** I authorize my health information to be used and/or disclosed for the following specific purposes:

• Treatment, Payment and Other Health Care Operations
• To manage my affairs on my behalf.

5. ***Your rights with respect to this authorization:***

6. *Your right to revoke:* I understand that I have the right to revoke this authorization at any time I also understand that my revocation of this authorization must be in writing. To obtain a copy of an authorization revocation form, I may contact:

Privacy Official
Teamsters Local 301 Health and Welfare Fund
36990 North Green Bay Road
Waukegan, IL 60087

7. *Your right to inspect or copy the health information to be used or disclosed:* I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed in accordance with this form. I understand that I will be charged a per page copying fee of .25 cents per page. I may arrange a mutually convenient time to come to Teamsters Local 301's Health and Welfare Fund office to inspect or obtain copies of my health information by contacting:

Privacy Official
Teamsters Local 301 Health and Welfare Fund
36990 North Green Bay Road
Waukegan, IL 60087

8. *Your right to receive a copy of this authorization.* I understand that if I agree to sign this authorization, which I am not required to do, I must be provided with a signed copy of it.

9. ***Expiration of Authorization:***

I understand that this authorization will remain in effect until the end of the last day of my final period(s) of coverage with Teamsters Local 301's Health and Welfare Plan or until I exercise my right to revoke the authorization.

I understand that my authorization to use and/or disclose my heath information does not constitute an authorization for any of my eligible dependents, over the age of 18, and that separate authorizations would need to made by these participants in the Plan.

I, _____ (please print name), 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.

_____ _____ / _____ / ____
Participant Signature Date

If the person whose PHI is to be disclosed is a spouse or dependent child over 18, the spouse or dependent child must sign below:

_____ _____

Signature of Spouse or Adult Child (over age 18) Print Name

If signed by a personal representative, complete the following:

Name of Personal Representative: _____

Relationship to participant or nature of Authority (e.g., health care power of attorney, guardian, other statutory authorization): _____

_____ _____ / _____ / _____

Signature of Personal Representative Date

Address: _____

_____

Home Phone No: _____ Work Phone No: _____

Submit this form to:
Privacy Official
Teamsters Local 301 Health and Welfare Fund
36990 North Green Bay Road, Waukegan, Illinois 60087