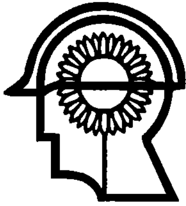

PLAN MANAGER
Gary Muckenthaler, CPA

KANSAS CONSTRUCTION TRADES
FRINGE BENEFIT FUNDS

P.O. BOX 5168
TOPEKA, KANSAS 66605-0168

4101 SW SOUTHGATE DR.
TOPEKA, KANSAS 66609-1227

PHONE: (785) 267-0140
TOLL FREE: 1-800-432-3595
FAX: (785) 267-9514

120-C

PROTECTED HEALTH INFORMATION (PHI) AUTHORIZATION FORM

PLEASE MAKE SURE ALL REQUIRED FIELDS ARE COMPLETED. IF YOU NEED ASSISTANCE IN COMPLETING THIS FORM, PLEASE CONTACT US AT THE NUMBER ABOVE. IF YOU DO NOT WISH FOR KBT TO RELEASE INFORMATION TO ANYONE OTHER THAN YOURSELF, THERE IS NOT NEED TO FILL OUT THIS FORM.

SECTION A: Individual authorizing use or disclosure (REQUIRED)

NAME: ______________________________ SOCIAL SECURITY NUMBER: ____________________

TELEPHONE NO.: (Day) ________________________ (Evening) ________________________

ADDRESS: ____
Street Apartment #

____
City State Zip Code

SECTION B: Scope of authority

I hereby authorize the Kansas Building Trades Open End Health and Welfare Trust Fund ("the Plan") to use or disclose my Protected Health Information (PHI) as described in this authorization. I understand that my PHI may include, but is not limited to, the following: medical records, emergency care records, billing statements, Explanation of Benefits, diagnostic imaging reports, transcribed hospital reports, laboratory reports, dental records, pathology reports, physical therapy records, hospital records (including nursing records and progress notes), claim status, claim information, confirmation or denial that treatment has occurred, treatment information, information on my physical or mental condition, and any personal and medical information related to the purpose of this authorization.

I further understand that my PHI may include information related to any of the following: genetic testing, mental health (excluding psychotherapy notes) HIV/AIDS, prescription medication, pregnancy, maternity, organ transplants, and chemical dependency (including alcohol and drug treatment). I authorize the use and/or disclosure of my Protected Health Information as indicated below.

SECTION C: Persons/Organizations authorized to use or disclose my PHI (REQUIRED)

KBT is authorized to **RELEASE** my PHI. (**IF YOU DO NOT WISH FOR KBT TO RELEASE INFORMATION TO ANYONE OTHER THAN YOURSELF, THERE IS NO NEED TO FILL OUT THIS FORM.**)

The following individuals or organizations are authorized to **RECEIVE** my PHI. (You **MUST** include Social Security Number or Employer Identification Number of each recipient, as well as your relationship to the recipient. In addition, please include addressees and phone numbers if known):

____

____

____.

HEALTH AND WELFARE FUND • TRUSTEES • PENSION

UNION TRUSTEES

Kevin Bayless
Matt Fierlage
Jamie Desmarais - Chairman
Todd Doree
Matthew Hall
Paul Garrett
Jeff Myers
Mitchell Rowley - Ex Officio
Rick Riley

MANAGEMENT TRUSTEES

Richard Kendall - Co-Chairman
Mike McGivern
Joel Kriss
Michael Gibson
John Lonker
Steve Mohan
Secretary/Treasurer

If you wish to place any conditions or limitations upon this authorization, please describe. (If you do not identify any conditions or limitations, the Plan will assume it may use or disclose all of your PHI within the scope of its authority, as set forth in Section B, above.):

____

____

(REQUIRED)

I understand that this authorization will expire on the following date: ____________________ **OR** upon the occurrence of the following event (e.g., death, loss of plan eligibility): ____

____, whichever comes first.

SECTION D: Terms and conditions of this authorization

I understand that I may refuse to sign this authorization. I understand that the Plan may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization. I further understand that if the person(s)/organization(s) authorized to receive my PHI are not health plan or health care providers, the disclosed information may no longer be protected by federal privacy regulations. I also understand that I may revoke this authorization at any time, in writing, except to the extent that action has been taken in reliance upon this authorization. Unless revoked earlier, this authorization will expire on the date or event specified above or upon disenrollment from the Plan.

SECTION E: Purpose of authorization

Purpose for which use or disclosure is authorized (NOTE: You are not required to provide a specific purpose; if left blank, the Plan will presume that the use or disclosure is simply being made at your request): ______________________________

____

____.

SECTION F: Signature (REQUIRED)

____________________________________ ________________________

Signature of Individual Date

If this authorization is signed by a personal representative on behalf of the subscriber, please complete the following:

Personal Representative's Name: ____

Relationship to the subscriber (e.g., parent, guardian, * or attorney-in-fact*): ______________________________

*Please attach legal documentation if you are the legal guardian or attorney-in-fact.

Please return completed and signed form to the following address:

KBT Health and Welfare Fund
Attn: Privacy Officer
4101 Southgate
P.O. Box 5168
Topeka, KS 66605-0168