IBEW LOCAL 683 HEALTH AND WELFARE FUND
AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Section A - Requesting an Authorization

I authorize the use/disclosure of my protected health information as described in Section B below. I understand that this authorization is voluntary and the IBEW Local Union 683 ("Fund") and entities with which the Fund has contracted to perform administrative duties ("Fund Entities"), will not condition treatment, payment, enrollment, or eligibility for benefits on receiving this authorization. If Fund Entities disclose this information, the recipient must obtain an additional authorization from me before it may re-disclose the information. Otherwise, information disclosed under this authorization may be re-disclosed by the recipient and no longer protected.

Name: ____________________________________ Social Security Number:_______________________

Address:__________________________________ Telephone Number:___________________________

____

Section B – Information for Use/Disclosure (NOTE: An additional form must be used if you are authorizing the use/disclosure of psychotherapy notes.)

Describe in detail the information to be used or disclosed (providers, dates of treatment, type of service, etc.):

____

____

Check here if your authorization includes the disclosure of information regarding AIDS, ARC or HIV testing/treatment

Check if your authorization includes the disclosure of information regarding:

Substance abuse (including alcoholism). The recipient of this information must obtain an additional authorization from me before they may re-disclose the information.

Mental Health Services (excluding psychotherapy notes)

Section C – Authorized Uses / Disclosures

Disclosure by Fund Entities:

I authorize the Fund Entities to disclose my protected health information described in Section B to the following persons and/or entities for their use: ____

I authorize the persons and / or entities listed above to use my protected health information described in Section B for the following purposes (or write "At My Request"): ____

Disclosure to Fund Entities:

I authorize the following persons and/or entities to disclose my protected health information described in Section B to the Fund Entities: ____

I authorize the Fund Entities to use my protected health information described in Section B for the following purposes:

____

Section D – Expiration and Revocation

This authorization will expire: On ______________; OR when the following occurs: ______________________________

I may revoke this authorization at any time by sending a written request on a standard form available by contacting 517-321-7502. I understand that revocation will not affect actions taken before receiving my request.

Section E – Signature

SIGNATURE: ____ DATE: ____________________

If a personal representative signs this authorization on behalf of the individual, specify your relationship to the individual including your authority to sign.

Personal Representative's Name: ____

Relationship to the individual and authority to sign: ____

(Unless you are the parent of a minor child, please provide proof of your relationship to the individual.)

WE WILL PROVIDE YOU A COPY OF THIS SIGNED AUTHORIZATION

INSTRUCTIONS FOR COMPLETING THE AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

The Authorization is not valid unless it is filled out completely.

Section A: Requesting an Authorization
1) Fill in the participant's or beneficiary's first and last name
2) Fill in the participant's full street address, including city, state and ZIP code
3) Fill in the participant's or beneficiary's Social Security number
4) Fill in the participant's or beneficiary's telephone number, including area code

Section B: Information for Use/Disclosure
1) List in detail the information to be used or disclosed. Fund participants and beneficiaries must check the appropriate boxes, if applicable for disclosures that:
   a. Include information related to substance abuse (including alcoholism)
   b. Include information related to mental health services

Section C: Authorized Uses/Disclosures
1) If the member would like the Fund to disclose his/her protected health information (PHI), check "Disclosure by Fund Entities" and list to whom this information shall be disclosed and the purpose for the disclosure.
2) If the member is requesting that others disclose their PHI to the Fund, check "Disclosure to Fund Entities" and list the person(s) who will disclose the information.

Section D: Expiration and Revocation
1) Fill in the date for when the authorization expires (day, month and year) or if applicable, the event/activity that will trigger the expiration of the authorization.
2) If the participant or beneficiary would like to revoke the authorization he/she may do so at any time. The request must be submitted in writing using the standard Fund revocation form. The participant or beneficiary may obtain a standard form by calling (844) 683-0683 or (517) 321-7502.

Section E: Signature
1) The participant or beneficiary must sign and date the authorization. If the individual that signs the authorization form is a personal representative, the individual must specify the relationship to the participant or beneficiary.
2) The personal representative must print his/her name and detail relationship to participant or beneficiary and authority to sign. If the personal representative is someone other than the parent of a minor child, written proof must be provided.

The requesting individual must be provided a copy of the completed authorization form. The original authorization form should be saved for future review and action surrounding the authorization.

Internal Use Only

This document needs to be retained and stored according to Fund procedures.