Electrical Workers Heath & Welfare Fund

Authorization for Release of Protected Health Information (PHI) By the Health Fund

You MUST complete all of the information requested in this form for your authorization to be valid.

I authorize the Fund the use of disclosure of my Protected Health Information (PHI) as described in this authorization. I understand the Fund may not condition my treatment, payment, enrollment or eligibility for benefits on whether or not I give the authorization listed in this form.

(1) **The Plan can release PHI to:** The Fund, its agents or subcontractors ("Business Associates") is authorized to release the PHI described below to the following person, class of persons, or organization:

□ My spouse □ My Union

□ My parents □ My Employer

□ Other (Print Name or Position): _____

(2) **The information that may be used or released is:**

□ Medical information held by the Fund from the following doctor, clinic, or hospital:

_____

□ Information held by the Fund concerning my eligibility, claims decisions and payments.

□ Other. Please specify below.

_____

_____

(3) **Right to revoke:** I understand that I have the right to revoke this authorization at any time by notifying the Fund's Contact Person in writing at the address listed at the top of this Form. 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.

(4) **Re-Release of Information:** I understand that after this information is released, federal law might not protect it and the recipient might re-release it. I also understand and agree to hold the Fund and any of its agents and subcontractors harmless if the information is re-released.

(5) **Copy:** I understand that the Fund will give me a copy of this authorization if requested.

(6) **THE AUTHORIZATION WILL EXPIRE ON THE DATE ON WHICH YOUR ELIGIBILITY UNDER THE PLAN TERMINATES UNLESS YOU SPECIFY ANOTHER DATE OR TERMINATION EVENT BELOW.**

□ Other: _____

Your Signature: _____ Date: _____

Print Your Name: _____

If you are covered under the Fund as a Dependent, please print the name and social security number of the covered employee:

Name: _____ SSN: _____

Mail or Fax Completed Forms to the Fund Administrator:

2002 London Road – Suite 300, Duluth, MN 55812
Fax: 218-728-4773