Authorization for Release of Protected Health Information ("PHI")

I. Participant / Patient Information

By signing this authorization form, I hereby authorize the Plumbers and Pipefitters Local No. 421 Health and Welfare Plan("Health Plan") to make the below described use(s) or disclosure(s) of my "Protected Health Information" ("PHI") as defined by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). I understand that this authorization is voluntary and may be revoked by me in writing at any time.

Participant Name:	**Participant SS#:**
Patient Name:	**Patient SS#:**
Address:	

II. Information regarding the Use or Disclosure of Protected Health Information

This authorization form may be as specific or as general as you wish. If you wish to authorize the use and disclosure of your PHI concerning a specific claim or claims please note the specific date(s) of service, and provider name(s) in the box to the left. If you wish to include any and all dates of service and providers, please write in "any and all" for date(s) ofservice and provider(s). Next, please describe the purpose for the use or disclosure of your PHI that you are authorizing. If you do not wish to state a purpose, please state "At the request of the individual."

Claim Information	Description of Purpose of Use or Disclosure:
Date(s) of Service:	
Provider(s):	

Person(s) Authorized to Receive the Above Described PHI

Please list the individual(s) or organization(s) to whom you are authorizing the Health Plan to make disclosures of your PHI.

_____

III. Expiration Date of Authorization

This authorization form will expire on _____ (NO LATER THAN 5 YEARS FROM THE DATE SIGNED) or upon the occurrence of the following circumstances or events:

_____

IV. Important Information Concerning Your Rights with Respect to this Authorization Form

I have read and understand the following statements concerning my rights:

- I may revoke this authorization prospectively at any time prior to its expiration date by notifying the Health Plan in writing.
- I understand that if I choose to revoke this authorization, the revocation will not apply to uses and disclosures that were previously made pursuant to said authorization
- I understand that, if I do sign this authorization, I should retain a signed copy of it.
- I understand that if the individual(s) or organization(s) authorized to receive my PHI are not Health Care Providers, Health Plans or Health Care Clearinghouses subject to federal privacy provisions, the PHI disclosed pursuant to this authorization may no longer be protected by the federal privacy standards; therefore my PHI may be redisclosed by the recipient without my authorization.
- I acknowledge that I am not required to sign this authorization form to receive my health care benefits; that is to enroll in the Health Plan, qualify for eligibility, seek treatment, or request payment for treatment. If I refuse to sign this authorization, the Health Plan will not deny me enrollment in the plan or eligibility for health care benefits.

V. Signature of Patient or Patient's Representative

I,_____ (please print your name), have reviewed and understand the contents of this authorization form.

By signing this form, I confirm that it accurately reflects my wishes.

_____ _____

Patient's Signature ***Date***

OR

IF YOU ARE THE PATIENT'S REPRESENTATIVE PLEASE COMPLETE THE SECTION BELOW.

Name of Patient's Representative:	Relationship to Patient:
Signature of Patient's Representative:	Date:
Address:	Telephone #:

If a Personal Representative executes the form on behalf of the individual, the Personal Representative warrants that he or she has the authority to sign this form on the basis of:

☐ A notarized power of attorney for health care purposes (COPY ATTACHED)

☐ A court order appointing the person as the individual's guardian or conservator (COPY ATTACHED)

☐ An unemancipated minor child's parent

☐ Other _____.