

LOCAL 805 WELFARE FUND
AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I _____ give permission for the release of my medical information,
(print name)
including, but not limited to, medical claims and health plan records, as described below.

- 1) The Welfare Fund (the "Fund") may disclose my medical information to (check all boxes that apply, and fill in the person's first and last name):
- My husband/wife: _____ (fill in your spouse's name)
 - Other relative: _____ (fill in other relative's name)
 - Union representative: _____ (fill in representative's name)
 - Other person or company (friend, attorney etc.): _____ (fill in person's or company name) (If more space is needed, please use the reverse side of this form.)
- 2) I give permission for the following medical information about me to be released over the telephone, in person, in writing or electronically to the person(s) listed in paragraph 1 above (or on the reverse side) (check one or more box(as), and fill in details):
- Any and all of my medical, dental, vision, prescription drug and other claims that the Fund has for all past and future dates of services
 - Specific medical, dental, vision, prescription drug or other claim(s) for health benefits (please fill in details below):
Provider(s) _____
Date of services _____
 - Dates of eligibility for health coverage
 - Other (please fill in) _____
- 3) The reason I am giving permission for the release of my medical information to the person(s) listed in paragraph 1 above (or on reverse side) is (check one box and, fill in the reason below):
- I'd prefer not to give a reason
 - For use for assisting me in processing my claims for medical services
 - Other reason _____ (please fill in)
- 4) I understand that I do not need to sign this form in order for the Fund to provide health benefits to me if I am eligible for those benefits.
- 5) I understand that after my medical information is released to the person(s) listed in paragraph 1 above (or on reverse side), that person is not required to keep my medical information confidential.
- 6) **Right to Revoke (Cancel) This Form:** If I no longer want the person(s) listed in paragraph 1 above (or on reverse side) to know about my medical information, then I must send a written letter to the Fund at _____, Attention: Privacy Officer, telling the Fund that I revoke (or cancel or take back) this form. I understand that the Fund cannot withdraw the medical information that the Fund has already released before I revoked (canceled) this form.
- 7) **Expiration of this Form:** This authorization form will expire on the date my eligibility for health benefits with the Fund ends, unless before that time, I notify the Fund in writing that I want the Fund to stop releasing my information to the person(s) listed in Paragraph 1 above (or on the reverse side)

Signature _____ Date _____

Social Security Number: _____ D.O.B: _____