U.F.C.W. Health & Welfare Fund

Authorization Form

Your Name: _____ Birth Date: ____/____/____
Please Print (Your Signature will be Required Below) MM DD YY

Your relationship with Participant: ☐Self ☐Spouse ☐Dependent Child
Participant's Name:

_____

Participant's Social Security Number or Member Number:

_____

Address:

_____

_____

Home Telephone Number: _____ Work Telephone Number: _____

I hereby authorize the U.F.C.W. Health and Welfare Fund (the "Fund") to use and/or disclose my Protected Health Information as follows:

1. **Information to be Used or Disclosed.** The following Protected Health Information (PHI) may be used and/or disclosed as described below (Check those that apply):

- ☐ Any health care information that you have about me.
- ☐ Any information that relates to my eligibility for benefits provided by the Fund.
- ☐ The dates of treatment that I received.
- ☐ The reason(s) that I was denied benefits.
- ☐ Other [Please describe the information in specific and meaningful fashion]

_____

_____

2. **Persons to Whom the Use or Disclosure May be Made.** The following person(s) or class of persons may receive the Protected Health Information described in Section 1 of this Authorization from the Fund Office and/or U.F.C.W. Health and Welfare Fund.

- ☐ Spouse's Name: _____
- ☐ Child(ren)'s Name(s): _____
- ☐ Parent(s)' Name(s): _____
- ☐ Business Agent or other staff member of Local Union or District Council
- ☐ Other Name: [List the name or specific identification of the person or classes of persons]

_____

_____

If you only want your PHI released to someone who knows a password, write your password here:

_____.

3. **Purpose of the Request.** Please state the purpose of the request below. If you do not wish to state a purpose, please state, "At the request of the individual."

_____

_____

_____

4. **Expiration Date or Event.** This authorization will expire (choose and complete one):

☐ Ten years from the date this authorization is signed

☐ On _____/_____/_____ (Less than 10 years from the date authorization is signed)
MM DD YY

☐ Upon the occurrence of the following event(s) related to my health care or to the purpose(s) for which I have authorized the use and/or disclosure of my Protected Health Information:

_____

_____

_____

I understand that:

(1) I may revoke this Authorization in writing at any time except to the extent that the Fund has taken action in reliance on this Authorization;
(2) The Fund may not condition treatment, payment, enrollment or eligibility for benefits on my willingness to sign this Authorization; and
(3) Any information disclosed under this Authorization may be subject to redisclosure by the recipient and may no longer be protected by law.

By: _____ **Date:** _____
[Your Signature]

Please return to the Fund Office at 27 Roland Avenue, Suite 100, Mount Laurel, NJ 08054, or by fax to 856-793-3100.