

U.F.C.W. Tri-State Health & Welfare Fund

Authorization Form

Your Name: _____
Please Print (Your Signature will be Required Below)

Birth Date: ____/____/____
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. Tri-State 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. Tri-State 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.