U.F.C.W. Tri-State 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. 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.

(Updated May 2014)