

## ***Instructions for completing the***

### **Authorization for Release of Protected Health Information**

There is a section for the Member/Retiree, Spouse and if applicable, a section for a dependent child(ren) over the age of 18.

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#### **Member Section /Retiree Section**

1. Fill in your name and social security number.
2. **If you are married** and you want to give your spouse authority to inquire about your health information, please enter his/her name and relationship (spouse) –or-  
**If you are not married or you want to give someone other than your spouse** authority to inquire about your health information, please enter his/her name and relationship (mother, father, friend, etc.).
3. **If you are giving someone else authority, please sign and date form.**

**OR**

**If you do not want to give anyone other than yourself** authority to inquire about your health information, then place an “X” in the box where it says, “I do not want my Health Information released to anyone but myself”. **Please sign and date below the box.**

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#### **Spouse Section**

1. Fill in your name and social security number.
2. **If you want to give your spouse (member/retiree)** authority to inquire about your health information, please enter his/her name and relationship (spouse).  
**If you want to give someone other than your spouse** authority to inquire about your health information, please enter his/her name and relationship (mother, father, friend, etc.), **please sign and date form.**

**OR**

**If you do not want to give anyone other than yourself** authority to inquire about your health information, then place an “X” in the box where it says, “I do not want my Health Information released to anyone but myself”.

3. **Please sign and date form below the box.**
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#### **Dependent(s) over the age of 18 Section**

1. Fill in your name and social security number.
2. **If you want to give your parents** authority to inquire about your health information, please enter their name and relationship (father, mother).  
**If want to give someone other than your parents** authority to inquire about your health information, please enter his/her name and relationship (mother, father, friend, etc.) **please sign and date form.**

**OR**

**If you do not want to give anyone other than yourself** authority to inquire about your health information, then place an “X” in the box where it says, “I do not want my Health Information released to anyone but myself”.

3. **Please sign and date form below the box.**

Only an electronic image copy of the Authorization Form will be kept on file at the Health Care Office. If you wish to retain a copy of the document for your records, please make one before mailing.

## Authorization for Release of Protected Health Information

### MEMBER/RETIREE SECTION

I, (Name, Please Print) \_\_\_\_\_, (Social Security #) \_\_\_\_\_, authorize the Health and Welfare Plan (the "Plan"), and its business associates, to disclose claims, payment, eligibility and other related health information about me to the following persons (select 1-2 persons if desired), at the request of such persons for benefit and claims inquiries:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

I understand that I have the right to revoke it at any time, except to the extent that it has already been relied upon. I understand that if I decide to revoke this authorization, I must give notice of my decision in writing and send it to:

**Hagerstown Teamsters & Motor Carriers Health & Welfare and Pension Fund**

**Attn: Eligibility Department**

**PO Box 1795**

**Troy, MI 48099**

I understand that my health information that is disclosed pursuant to this authorization may be re-disclosed by the persons I have identified above, and the Plan cannot prevent or protect such re-disclosures, AND I understand that I am not required to sign this form to receive my health care benefits (enrollment, treatment or payment).

Signature of Member \_\_\_\_\_ Date Signed: \_\_\_\_\_

-OR- ☐ I do not want my Health Information released to anyone but myself.

Signature of Member \_\_\_\_\_ Date Signed: \_\_\_\_\_

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### SPOUSE SECTION

I, the spouse (Name, Please Print) \_\_\_\_\_, (Spouse's Social Security #) \_\_\_\_\_ of the above-named member, have also read, understand, and authorize the Plan to disclose claims, payment, eligibility and other related health information about me to the following persons (select 1-2 persons if desired) for the reasons and with the explanations listed above, at the request of such persons:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Signature of Spouse \_\_\_\_\_ Date Signed: \_\_\_\_\_

-OR- ☐ I do not want my Health Information released to anyone but myself.

Signature of Spouse \_\_\_\_\_ Date Signed: \_\_\_\_\_

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### DEPENDENT(S) 18 AND OVER SECTION

I, the dependent child(ren) 18 or older (Name, Please Print) \_\_\_\_\_, (Social Security #) \_\_\_\_\_ have also read, understand, and authorize the Plan to disclose claims, payment, eligibility and other related health information about me to the following persons (select 1-2 persons if desired) for the reasons and with the explanations listed above, at the request of such persons:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Signature of Dependent \_\_\_\_\_ Date Signed: \_\_\_\_\_

OR- ☐ I do not want my Health Information released to anyone but myself.

Signature of Dependent \_\_\_\_\_ Date Signed: \_\_\_\_\_

NOTE: If there is more than one dependent 18 and over, please copy, complete and sign the appropriate number of additional Authorization Forms and return to the Fund Office.
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