

\*«BARCODE«\*

**Authorization for Release of Protected Health Information**  
MEMBER/RETIREE SECTION

I «**FULLNAME**» 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 12 persons if desired), at the request of such persons:

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

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

I understand that this authorization will expire upon termination of my enrollment in the Plan, unless I revoke it sooner. 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:

HIPAA Contact Person  
Heat & Frost Insulators of Northern California Local 16 Health and Welfare Plan  
P.O. BOX 2684  
San Ramon, CA 94583

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) OVER THE AGE OF 18 SECTION**

I, the dependent child(ren) over the age of 18 (**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 over the age of 18, please copy, complete and sign the appropriate number of additional Authorization Forms and return to the Benefit Office.