Dependent of: «MEMBERNAME»
Alt ID.: «MEMBERBENESYSID»

«FULLNAME»
«ADDRESSLINE1»
«ADDRESSLINE2»
«ADDRESSLINE3»

DEPENDENT'S AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I,(print name and social security number)_____, authorize 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:

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:

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 disclosed by the persons I have identified above, and the Plan cannot prevent or protect such 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 Dependent_____**Date Signed:** _____

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

Signature of Dependent_____**Date Signed:** _____