Iron Workers'
Local 25

Authorization for Release of Protected Health Information

Participant

I, **(Print Name)**_____, (**Social Security #**)_____, a participant in the Iron Workers' Health Fund of Eastern Michigan (the "Plan"), authorize the Plan and its business associates, to disclose claims, payment, eligibility, and other related health information about me (except information contained in psychotherapy notes) 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 twelve months after I am no longer eligible for benefits under 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 the IW Health Fund of Eastern Michigan, P. O. Box 8006, Novi, MI 48376-8006.

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

Signature of Participant_____ Date Signed: _____

Spouse

I, the **spouse** of the above named participant (Please PRINT Name) _____, have read the above Participant section and understand its terms. I authorize the Plan to disclose claims, payment, eligibility, and other related health information (except information contained in psychotherapy notes) about me to the following persons (select 1-2 persons if desired) for the reasons stated and subject to the conditions listed in the Participant section above, at the request of such persons:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Signature of Spouse _____Date Signed: _____

Adult Dependent Child

I, the **dependent child** over the age of 18 of the above named participant (Please PRINT Name) _____, have read the above participant section and understand its terms. I authorize the Plan to disclose claims, payment, eligibility, and other related health information about me (except information contained in psychotherapy notes) to the following persons (select 1-2 persons if desired) for the reasons stated and subject to the conditions listed in the Participant section above, at the request of such persons:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Signature of Adult Dependent Child_____ Date Signed: _____

W0281454
06'06 *bld.opeiu42aflcio*

Upon request, the Plan will provide a copy of this signed authorization.