

**Instructions for completing the**

**Authorization for Release of Protected Health Information**

There is a section for the Member/Retiree, Spouse/Domestic Partner 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/Domestic Partner Section**

1. Fill in your name and social security number.
2. **If you want to give your spouse/domestic partner (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/domestic partner** 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.**

**(Over)**

## Authorization for Release of Protected Health Information

### MEMBER/RETIREE SECTION

I, (print your name and Social Security number) \_\_\_\_\_ 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:

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:

IBEW 125 – PGE Health & Welfare Trust  
P.O. Box 1929  
Portland, OR 97207  
Phone 503-224-5906 • Toll Free 877-545-9471

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/domestic partner (Name, Please Print) \_\_\_\_\_, (Spouse's/Domestic Partner'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/Domestic Partner** \_\_\_\_\_ **Date Signed:** \_\_\_\_\_

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

**Signature of Spouse/Domestic Partner** \_\_\_\_\_ **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, except 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.