

## AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

### **MEMBER / RETIREE SECTION**

I, (print name and social security number) \_\_\_\_\_ SSN# \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
authorize the Health Fund (the "Fund"), 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 Fund, 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  
Indiana/Kentucky/Ohio Regional Council of Carpenters' Welfare Fund  
P.O. Box 969  
Troy, MI 48099-0969  
Phone: (800)700-6756  
(317) 851-4168  
[www.in-kycarpentersbenefits.org](http://www.in-kycarpentersbenefits.org)

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 Fund 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:** \_\_\_\_\_

### **SPOUSE SECTION**

I, the Spouse (Name, Please Print) \_\_\_\_\_, (Spouse's Social Security #) \_\_\_\_\_ of the above named member, have also read, understand, and authorize the Fund 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:** \_\_\_\_\_

### **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 Fund 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 Fund Office.