Iron Workers St. Louis District Council Trust Funds

P.O. Box 1096 • Maryland Heights, MO 63043 • Phone 314.656.1091 • Toll Free 877.597.8704 • Fax 314.739.1105

Authorization To Use Or Disclose Health Information

Injured Parties Name:_____ Subscriber ID: _____

I, the undersigned, hereby authorize the Iron Workers St. Louis District Council Trust Fund to use or disclose the following protected health information about the above named patient's subrogation file for date of injury _____.

☐ **Complete subrogation file** (includes all available information listed below)

☐ **Total subrogated amount** (Letter stating the total paid on the patient's behalf)

☐ **Limited claims payment detail** (Service date, provider, amount paid)

☐ **Complete claims detail** (Service date, provider, procedure (CPT) codes, diagnosis (ICD-9) codes, billed amount, allowed amount, and amount paid)

I authorize disclosure of the above listed information to the following organization(s)/parties at the address listed below:

Attorney:_____

_____

Insurance Carrier:_____

_____

Other (Please provide complete detail as to who this individual/Company is):

_____

_____

I understand I have the right to revoke this authorization, in writing, at any time, by presenting my written cancellation to the Benefit Office, Attorney, Insurance Carrier, or other party as listed above. I understand the cancellation will not apply to information that has already been released under this authorization.

X _____

Subscriber/Guardian Signature Date