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
Mahoning/Trumbull County Building Trades Insurance Fund
3660 Stutz Drive, Ste. 101
Canfield, OH 44406
(330) 779-8859
www.mahoningtrumbullbenefits.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.