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 person(s) (select up to 2 people), at the request of such person(s):

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:

Ohio Bricklayers' Fringe
Benefit Funds
P.O. Box 99550
Troy, MI 48099
Phone: (248) 641-4921 Toll Free: (833) 289-4921
Website: ohiobricklayersbenefits.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 person(s) (select up to 2 people), at the request of such person(s):

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 person(s) (select up to 2 people), at the request of such person(s):

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.