Authorization for Release of Protected Health Information

The "Plan" as referred to on this form is the PAINTERS DISTRICT COUNCIL #2 WELFARE PLAN.

MEMBER/RETIREE SECTION

I, (Print Name)_____,(Social Security #)_____ authorize 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 have read and understand the section of this form entitled **Expiration, Revocation, and Redisclosure.**

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** (Print Name) _____, (Spouse's Social Security #) _____ of the above named member 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: _____

I have read and understand the section of this form entitled **Expiration, Revocation, and Redisclosure.**

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 – copy and submit one form for each.

I, the **dependent** over the age of 18 (Print Name)_____, (Social Security #) _____ 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: _____

I have read and understand the section of this form entitled **Expiration, Revocation, and Redisclosure.**

Signature of Dependent_____**Date Signed** _____

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

Signature of Dependent_____**Date Signed** _____

Expiration, Revocation, and Redisclosure

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: PAINTERS DISTRICT COUNCIL #2 WELFARE PLAN, P.O. BOX 1186, Maryland Heights, MO 63043-1186.

I understand that my health information that is disclosed pursuant to this authorization may be redisclosed by the persons I have identified above, and the Plan cannot prevent or protect such redisclosures, AND I understand that I am not required to sign this form to receive my health care benefits (enrollment, treatment or payment).