SHEET METAL WORKERS LOCAL 162 HEALTH CARE PLAN
P. O. Box 1677
San Ramon, CA 94583
Telephone: (925) 208-9992 (866) 787-0162

Authorization for Release of Protected Health Information

Dear Participant:

Privacy regulations require the Fund Office to have authorization to discuss health care and eligibility information over the phone. The enclosed Authorization Form allows you to permit the Fund Office to discuss health care and eligibility information with the person(s) you designate on the form. If you so choose, the form also permits you to limit the release of health information to yourself only.

If the Authorization Form is not completed and returned, discussions regarding health care will be limited to yourself and any minor children enrolled under your coverage. This means that if your spouse calls the Fund Office with a question about a benefit paid on your behalf, we will not be able to release the information. Similarly, if your spouse does not give authorization for us to talk to you, you will not be able to inquire about a claim paid on your spouse.

Please review the instructions for completing the Authorization Form on the back of this letter. Note the form contains three sections that must be completed and signed by each:

1) Member/Retiree
2) Spouse
3) Dependent(s) over the age of 18

We have enclosed a return stamped envelope for your convenience.

Please **avoid any unnecessary inconvenience** by completing, signing, and returning the enclosed Authorization Form. You may revoke your authorization at anytime.

Yours truly,

Fund Office
Northern California Sheet Metal Workers Health Care Plan

Instructions for completing the- *Authorization for Release of Protected Health Information*

The form has sections for Member/Retiree, Spouse, and Dependent(s) over the age of 18. Each section must be completed and signed by the appropriate individual. You may wish to copy the completed form for your records.

Member / Retiree Section

1. Fill in your name and social security number.
2. **If you are married** and you want to give your spouse authority to inquire about your health information, please enter his/her name and relationship (spouse) –or-
   If you are not married <u>or</u> you want to give someone other than your spouse authority to inquire about your health information, please enter his/her name and relationship (mother, father, friend, etc.).
3. **If you are giving someone else authority, <u>please sign and date form</u>**

OR

If you do not want to give anyone other than yourself authority to inquire about your health information, place an "X" in the box where it says, "I do not want my Health Information released to anyone but myself". **<u>Please sign and date below the box</u>**.

Spouse Section

1. Fill in your name and social security number.
2. **If you want to give your spouse (member/retiree)** authority to inquire about your health information, please enter his/her name and relationship (spouse).
   If you want to give someone other than your spouse authority to inquire about your health information, please enter his/her name and relationship (mother, father, friend, etc.).
3. **If you are giving someone else authority, <u>please sign and date form</u>**

OR

If you do not want to give anyone other than yourself authority to inquire about your health information, place an "X" in the box where it says, "I do not want my Health Information released to anyone but myself". **<u>Please sign and date form below the box</u>**.

Dependent(s) over the age of 18 Section

1. One form must be submitted for each dependent over the age of 18. Please make additional copies of the form if necessary.
2. Fill in your name and social security number.
3. **If you want to give your parents** authority to inquire about your health information, please enter their name and relationship (father, mother).
   If want to give someone other than your parents authority to inquire about your health information, please enter his/her name and relationship (friend, etc.).
4. **If you are giving someone else authority, <u>please sign and date form</u>**

OR

If you do not want to give anyone other than yourself authority to inquire about your health information, place an "X" in the box where it says, "I do not want my Health Information released to anyone but myself". **<u>Please sign and date form below the box</u>**.

Authorization for Release of Protected Health Information

The “Plan” as referred to on this form is the Northern California Sheet Metal Workers Health Care Plan.

MEMBER/RETIREE SECTION

I, (Name)____(SSN)____________________________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: Northern California SMW Health Care Plan, P. O. Box 1677, San Ramon, CA 94583.

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).