***Instructions for completing the:***

# Authorization for Release of Protected Health Information

There is a section for the Member/Retiree, Spouse/Domestic Partner and if applicable, a section for a dependent child(ren) over the age of 18.

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**Member Section /Retiree Section**

1. Fill in your name and social security number.
2. **If you are married** and you want to give your spouse/domestic partner authority to inquire about your health information, please enter his/her name and relationship (spouse or domestic partner) –or-
   **If you are not married** or **you want to give someone other than your spouse/domestic partner** 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, please sign and date form.**

**OR**

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

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**Spouse/Domestic Partner Section**

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

**OR**

**If you do not want to give anyone other than yourself** authority to inquire about your health information, then place an "X" in the box where it says "I do not want my Health Information released to anyone but myself".

3. **Please sign and date form below the box**.

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**Dependent(s) over the age of 18 Section**

1. Fill in your name and social security number.
2. **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 (mother, father, friend, etc.) **please sign and date form.**

**OR**

**If you do not want to give anyone other than yourself** authority to inquire about your health information, then place an "X" in the box where it says "I do not want my Health Information released to anyone but myself".

3. **Please sign and date form below the box**.

## Authorization for Release of Protected Health Information

MEMBER/RETIREE SECTION

I, the **participant (Print name)** _____ **SSN:** _____ authorize the Health and Welfare Plan (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 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:

**U.A. LOCAL 393 FRINGE BENEFIT FUNDS**
**P.O. BOX 2460**
**SAN JOSE, CA 95109-2460**

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).

**Signature of Member** _____ **Date Signed:** _____

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

**Signature of Member** _____ **Date Signed**: _____

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**SPOUSE/DOMESTIC PARTNER SECTION**

I, the **spouse/DP** (**Print name**), _____ **Spouse/DP SSN** _____ of the above named member, have also read, understand, and 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: _____

**Spouse/DP Signature** _____ **Date Signed**: _____

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

**Spouse/DP Signature** _____ **Date Signed**: _____

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**DEPENDENT(S) OVER THE AGE OF 18 SECTION**

I, the **dependent child(ren)** over the age of 18 (**Print name)** _____ ,**SSN** _____ have also read, understand, and 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: _____

**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.