United Association Local No. 7 Welfare Plan
Authorization Form

(For Use or Disclosure of Protected Health Information)

In order for the United Association Local No. 7 Welfare Plan to use or disclose Protected Health Information ("PHI") to someone other than you, you must complete this Authorization Form and return it to the Plan's Administrator, 18 Avis Drive, Latham, NY 12110, Tel. (518) 785-9808.

In order for your medical information to be considered PHI, it must satisfy the following conditions: (a) your medical information must be "health information." Health information is broadly defined in the applicable HIPAA regulations as meaning any oral or recorded information relating to your past, present, or future physical or mental health, the provision of health care for you, or the payment of health care for you; (b) your medical information must be "individually identifiable." Individually identifiable health information is broadly defined in the applicable HIPAA regulations as health information that identifies or reasonably can be used to identify you (the Plan may de-identify your individually identifiable health information by removing specific identifiers including, but not limited to your name, Social Security number, and address); and (c) your medical information must be "created or received" by a covered entity (this Plan and your doctor are covered entities under the applicable HIPAA regulations). Individually identifiable health information that is created or received by a covered entity is protected.

Except as permitted by law, the Plan may not use or disclose PHI to persons other than those you specify on this form. The Plan may request that you complete this form where the use or disclosure of information is necessary to carry out functions of the Plan. In addition, you may submit this form to the Plan because you want someone to request or receive your PHI from the Plan. This form is not needed if you are requesting your own PHI from the Plan. The Plan has a separate form for that type of request.

Name: _____

Social Security Number: _____

Mailing Address: _____

Phone: (_____)_____

I, _____ (please print name), a Participant in a HIPAA-covered program, authorize the use and disclosure of my PHI as described in this Authorization Form.

AUTHORIZED PERSONS OF THE PLAN TO USE AND DISCLOSE PHI

Plan employees who assist in the Plan's administration are authorized persons to disclose PHI.

AUTHORIZED PERSONS TO RECEIVE AND USE PHI

The specific person(s) (or class of persons) listed below is an authorized person(s) (or class of persons) to receive and use PHI:

_____ _____

Name/Title Phone Number

_____

Organization Name and Address

DESCRIPTION OF THE INFORMATION TO BE DISCLOSED

Please describe the information to be disclosed. For example, "Medical examination report and conclusions related to a fitness-for-work exam or payment history for my long term care coverage."

All correspondence regarding premium payment(s) and participation in the Welfare Fund, including Health Reimbursement Account (HRA) balance and any information related to claim reimbursement.

PURPOSE OF DISCLOSURE

Please state the purpose of the request below. For example, "To discuss my benefits with my financial counselor." If you do not wish to state a purpose, you may state "At the request of the Participant."

At the request of the Participant.

VALIDITY OF AUTHORIZATION FORM

The Plan will provide a copy of this signed Authorization Form to you. This Authorization Form is valid until the earliest of: **(Circle one)**

a. _____(please provide date or event)
b. the date the Plan receives your Cancellation of Authorization Form
c. one year from the date you sign this Authorization Form

ACKNOWLEDGMENT & SIGNATURE

I understand that:

a. I have the right to refuse to sign this Authorization Form and that the Plan may not condition Treatment, Payment, enrollment, or eligibility for benefits on whether I sign this Authorization Form except for limited circumstances;
b. I have the right to revoke this Authorization Form at any time by submitting a Cancellation of Authorization Form to the Plan;
c. the Cancellation of Authorization Form will take effect as of the cancellation date or event, or once the Plan receives the Cancellation of Authorization Form; and
d. the specific person(s) or class of persons authorized to receive and use my PHI may not be required to treat this information as confidential.

Signature: _____ Date: _____
Participant

PERSONAL REPRESENTATIVE

If you are acting as the personal representative of the Participant whose PHI is to be disclosed and you sign this Authorization Form, you must provide proof of your authority to act for the Participant. You warrant that you have authority to sign this Authorization Form on the basis of:

_____

_____

_____

_____

Signature: _____ Date: _____
Personal Representative

(Note: Requests made by Personal Representatives must be made in accordance with the United Association Local No. 7 Welfare Plan's Recognition of Personal Representative Policy.)

Return completed form to:

United Association Local No. 7 Welfare Plan
18 Avis Drive
Latham, NY 12110

Phone – (518) 785-9808