NEW YORK CITY DISTRICT COUNCIL OF CARPENTERS WELFARE FUND

AUTHORIZATION FORM

For Use of Disclosure of Protected Health Information

PURPOSE OF THIS FORM

Under the Health Insurance Portability & Accountability Act (HIPAA), in order for the Welfare Fund to use or disclose Protected Health Information to someone other than you, you must complete this Authorization Form and return it to the Fund.

Protected Health Information "PHI" is information that is created, received, transmitted or stored by the Fund which relates to your past, present, or future physical or mental health, health care, or payment for health care, and either identifies you or provides a reasonable basis for identifying you. Except as permitted by law, the Fund may not use or disclose PHI to persons other than those you specify on this form.

The Fund may request that you complete this form where the use of disclosure of information is necessary to carry out functions of the Fund. In addition, you may submit this form to the Fund because you want someone to request or receive your PHI from the Fund. This form is not needed if you are requesting your own PHI from the Fund.

Name: _____ UBC#_____

I hereby give permission to the Welfare Fund, or any of its affiliates or agents and their staff performing services in connection with my claim for health plan benefits, to disclose my protected health information (PHI) identified in Section #3 of this Form to the following class persons:

Spouse_____

Employer or the Fund New York City District Council of Carpenters Pension Fund_____

Business Manager, Union Official or Agent_____

Other Person(s) New York County Health Services Review Organization/Med Review_____

I authorize the Welfare Fund to disclose PHI (including written, electronic, or oral information) to the person(s) identified in Section #2 of this form in connection with (mark all that apply): (if you want different people to have access to different information, you must fill out separate forms.)

__ Hospital/Medical Claims __ Prescription Drug Claims __Vision Claims

__ Mental Health Claims __ Dental Claims __ Hearing Aid Claims

__ Specific claim for health benefits __ Disability Claim information

(describe the event or claims involved with the date of service)

_____

_____

The purpose of the use of disclosure of my protected health information (PHI) is:

_____
_____
_____

NOTE: “at the request of the individual” is a sufficient description of the purpose.

This Authorization form is valid until:

1. _____ (please provide date of event);
2. The date the Fund receives my Cancellation of Authorization Form; or
3. If not otherwise indicated in (1) above, one year from the date I sign this form.

I understand that:

- I HAVE THE RIGHT TO REFUSE TO SIGN THIS AUTHORIZATION FORM.
- I HAVE THE RIGHT TO REVOKE THIS FORM AT ANY TIME BY SUBMITTING A CANCELLATION OF AUTHORIZATION FORM TOP THE WELFARE FUND. CANCELLATION WILL TAKE EFFECT AS OF THE CANCELLATION DATE OR EVENT, OR ONCE THE WELFARE FUND RECEIVES THE CANCELLATION OF AUTHORIZATION FORM.
- THE PERSON(S) I AM AUTHORIZING TO RECEIVE MY PHI MAY NOT BE REQUIRED TO TREAT THIS INFORMATION AS CONFIDENTIAL.
- TREATMENT, PAYMENT, ENROLLMENT AND ELIGIBILITY FOR BENEFITS MAY NOT BE CONDITIONED ON OBTAINING AN AUTHORIZATION.

_____ _____

Your Signature (or Signature of Personal Representative*) Date

*If you are acting as the personal representative of the individual whose PHI is to be disclosed, you must provide proof of your authority to act for that individual.