SOUTHERN CALIFORNIA PIPE TRADES HEALTH & WELFARE FUND

HWM-F023 (rev060208)

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AUTHORIZATION FORM

PURPOSE OF FORM

In order for the Southern California Pipe Trades Health & Welfare ("Fund") to use or disclose your 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 or 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.

PATIENT INFORMATION

NAME: ______________________________

STREET: ______________________________

CITY: ______________________________

ZIP & STATE: ______________________________

SSN: ________-________-________

Are you a dependent? ☐ **YES** ☐ **NO**

If **YES**, please state:

Relationship to member: ______________________

Member's Name: ______________________

Member's SSN: ______________________

PART I: Authorized Person

I authorize the Fund to disclose my protected health information (PHI) identified in Part II of this form to the following person. (Please designate no more than one person and provide their name and address. If you want different individuals to have access to different information, please fill out separate forms for each individual.)

____

FIRST **Middle Initial** **LAST**

____

STREET **CITY** **STATE** **ZIP**

RELATIONSHIP: ☐ **SPOUSE** ☐ **FAMILY** ☐ **OTHER:** ______________________

PART II: Effective Period of the Form

This Authorization Form is valid for the period designated below:

☐ **For as long as I am eligible for benefits under the Plan;**

☐ **Until ______________________ (please provide date or event);**

☐ **Until I cancel by submitting a Cancellation of Authorization Form.**

(You may also cancel this authorization at any time, no matter which option you select above, by submitting to the Fund Office a properly completed Cancellation of Authorization Form)

PART III: Description of Information

I authorize the Fund to disclose my protected health information (PHI) – including written, electronic, or oral information, to the person(s) identified in Part I of this form in connection with the following information:

- ☐ **ALL claims information for benefits covered under the Plan for the period authorized in Part I**
- ☐ **SPECIFIC claims information (Mark all that apply below)**
  - ☐ **ALL MEDICAL claims**
  - ☐ **ALL VISION claims**
  - ☐ **ALL PRESCRIPTION claims**
  - ☐ **Claims by SPECIFIC PROVIDER**
    Provider Name : ______________________
    Date of Services : ______________________
  - ☐ **ALL DENTAL claims**
  - ☐ **ALL MENTAL claims**
  - ☐ **Claims in a SPECIFIC PERIOD**
    ____________ **To** ____________
    (MM/DD/YY) **(MM/DD/YY)**
  - ☐ **OTHERS:** ______________________________
    ____
    (Please be specific)

PART IV: Purpose of use or disclosure

The purpose for which the individual named in Part I of this Authorization Form may have access to my PHI is as follows: (Please mark all that apply.)

- ☐ **For any purpose**
- ☐ **Payment for health care**
- ☐ **Eligibility in Fund**
- ☐ **Preauthorization**
- ☐ **Health care claims or appeals**
- ☐ **Coordination of benefits**
- ☐ **Premiums and co-payments**
- ☐ **Subrogation and Reimbursement**
- ☐ **Other purpose (explain):** ____

PART V: Acknowledgement and SIGNATURE

I understand that :

- **The Fund will provide a copy of this signed Authorization to me**
- **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 to the Fund**
- **Cancellation will take effect as of the cancellation date or event, or once the fund receives a Cancellation of Authorization Form**
- **The person I am authorizing to receive my PHI may not be required to treat this information as confidential**

____
Your Signature
(or Signature of Personal Representative*)

____
Print Name

**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.*