INTERNATIONAL UNION OF OPERATING ENGINEERS
LOCAL 4
Health and Welfare Fund

Authorization For Release of Protected Health Information

I, _____, (Please PRINT Name) hereby authorize the use or disclosure of my health information as described in this authorization.

My date of birth: _____

My Social Security Number: _____

My Home Address: _____

By signing this authorization form, I authorize the IUOE Local 4 Health and Welfare Fund to use and/or disclose my health information (information that constitutes protected health information as defined in the Privacy Rule of the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996) in the manner described on this form. **I understand that I am under no obligation to sign this form.**

1. Specific organization authorized to provide the information:
   IUOE Local 4 Health and Welfare Fund

2. Specific person/organization authorized to receive and use the information:

   Name: _____

   Address: _____

   Phone #: _____

3. Specific and meaningful description of the information: **Please describe the specific information you wish the IUOE Local 4 Health and Welfare Fund to disclose.**
   [*Example Only: written, electronic and oral information related to eligibility for benefits for the time period commencing on mmddyy date and continuing through mmddyy date.*
   Example Only: written, electronic and oral information including claims, reports, and other documents related to claims for benefits for an injury or illness commencing on mmddyy date and continuing through mmddyy date.
   Example Only: written, electronic and oral information relating to payment or lack of payment of benefits to [name of health care provider] for services rendered on mmddyy date.]

   Please specify in the space provided below

_____

_____

_____

Please review and complete the opposite side of this form as well

16 Trotter Drive
P.O. Box 660
Medway, MA 02053-0660

TEL (508) 533-1400
FAX (508) 533-1404
1-888-486-3524

www.local4funds.org

Authorization For Release of Protected Health Information (cont'd)

4. Purpose of the request: **Please state the purpose of the request below.**
   [*Example: to discuss my benefits with the Fund so that I can better understand my benefits.*]
   If you do not wish to state a purpose, please state, "At the request of the individual."

   _____

   _____

   _____

5. Right to Revoke:
   I understand that I have the right to revoke this authorization at any time by notifying the **Privacy Officer** of the IUOE Local 4 Health and Welfare Fund, in writing at PO Box 660 Medway, MA 02053. I understand that the revocation is only effective after it is received and logged by the **Privacy Officer**. I understand that any use or disclosure made prior to the revocation under this authorization will not be affected by a revocation.

6. I understand that after this information is disclosed, federal law might not protect it and the recipient might disclose it again.

7. I understand that I am entitled to receive a copy of this authorization.

8. I understand that this authorization will expire on: *Please indicate a specific date (E.g., January 31, 2003), or specific time period (E.g., 6 Months from date of my signature), or event (E.g., On the date the disclosure of information is completed).*
   Note: The authorization time frame may not exceed 12 months per IUOE Local 4 Health & Welfare Fund Policy

   _____

9. The IUOE Local 4 Health and Welfare Fund will not condition treatment, payment, enrollment, or eligibility for health plan benefits on receipt of an authorization.

   I, _____, (Please PRINT Name) have had an opportunity to review and understand the contents of this form. By signing this form, I am confirming that it accurately reflects my wishes.

   _____ _____
   Signature Date

   If a Personal Representative executes this form, that Representative warrants that he or she has authority to sign the form on the basis of:

   _____

Instructions for Completing the HIPAA Authorization Form Enclosed

Step 1. Please print your full first and last name in the space provided in the very first sentence of the authorization form. This is the name of the person whose information will be released.

Step 2. Please indicate your date of birth, social security number, and home address in the spaces provided for this information on the form. This is the information of the person whose information will be released.

Step 3. Please indicate the name, address, and telephone number of the person or organization you are authorizing to receive and use your information. ***** Item # 2 of the form**

Step 4. Please specify the specific information you are authorizing the IUOE Local 4 Health and Welfare Fund to disclose. ***** Item # 3 of the form ***** The information in this section must be very specific. A few examples have been provided on the form for you.

Step 5. Please specify the purpose of the request in the space provided in **item # 4 of the form**. If you do not wish to state a purpose, please state: "**At the request of the individual.**"

Step 6. Please indicate a specific expiration date, time period, or event in **item # 8 of the form**. In no event shall the expiration date exceed 12 months from the date of signature on the form, as per IUOE Local 4 Health and Welfare Fund Policy.

Step 7. Please print your name in the final statement (**item # 9 of the form**) of the form in the space provided. Sign and date the form, then mail/fax it back to the IUOE Local 4 Health and Welfare Fund office. If an authorized personal representative completes this form on behalf of a plan participant, you must submit evidence of your authorization to represent the plan participant, such as proof of Power of Attorney.

FAX (508) 533-1404 ATTN: Privacy Officer

Mail: IUOE Local 4 Health and Welfare Fund
ATTN: Privacy Officer
PO BOX 660
Medway, MA 02053

You may also contact us for clarification, and/or assistance with completing the form at: 1-888-486-3524