



Authorization For Use or Disclosure of Protected Health Information (PHI)

Section A: Must be completed for all authorizations

I hereby authorize the use or disclosure of my Protected Health Information described below. I understand that this authorization is voluntary. I understand that the released information will no longer be protected by federal privacy regulations.

Participant Name: _____

S.S. Number: _____

Persons/organizations providing the information:

Persons/organizations receiving the information:

Check-off the applicable box(es) below for the type of information you authorize the Cement Masons Health and Welfare Trust Fund for Northern California, Health and Welfare Plan to disclose:

- All information about participant and family members including status of claims, eligibility and coverage information.
- Participant Information Only Dependent Information Only Claims Status Only Coverage Information Only
- Other (please specify) _____

Section B: Must be completed only if the Cement Masons Health and Welfare Trust Fund for Northern California, Health and Welfare Plan or its Business Associate has requested the authorization:

1. The Cement Masons Health and Welfare Trust Fund for Northern California, Health and Welfare Plan must complete the following:
 - a. What is the purpose of the use or disclosure?

 - b. Will the organization requesting the authorization receive financial or in-kind compensation in exchange for using or disclosing the health information described above? Yes No
2. The participant or the participant's representative must read and initial the following statements:
 - a. I understand that my health care and the payment for my health care will not be affected if I do not sign this form.
Initials: _____
 - b. I understand that I may see and copy the information described on this form if I ask for it, and that I get a copy of this form after I sign it.
Initials: _____

Section C: Must be completed for all authorizations:

The participant or the participant's representative MUST READ, COMPLETE AND INITIAL the following statements:

1. I understand that this authorization will start on (indicate dates) ____/____/____ and expire on ____/____/____. Note: If you do not indicate the dates above, we will use the signed date below as start date and not revoke this authorization until you notify us in writing. Initials: _____
2. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, but if I do it will not have any affect on any actions they taken before the organization received the revocation.
Initials: _____

Signature of participant
(Form documenting representative status must be completed before signing.)

Date

Printed name of participant

• YOU MAY REFUSE TO SIGN THIS AUTHORIZATION •

