Cement Masons Health and Welfare Trust Fund for Northern California

Authorization for Release of Protected Health Information (PHI)

I. Information About the Use or Disclosure PHI

Participant name: _____ SSN (last 4)/ID: _____

I, _____, hereby authorize the use and disclosure of PHI for*:
(*insert the name of the individual whose is authorizing the release of the information)*

☐ Myself, **OR**

☐ _____

(insert the name of individual on whose behalf you are making the request as a Personal Representative)*

1. Organization authorized to release and/or disclose PHI:
   - ☒ Health Service & Benefit Administrators (third party administrator for the Trust Fund)
   - ☐ Other, please specify: _____

2. Person or organization (or class of persons/organizations) authorized to receive the information:
   Name: _____ Daytime Telephone: (___) _____ - _____
   Address: _____

3. Check the boxes to describe the specific description of information to be used or disclosed:
   - ☐ Related to eligibility for benefits for the period of _____ through _____
   - ☐ Related to claims, reports and other documents for benefits for an injury or illness
   - ☐ Related to payment or lack of payment of benefits for all health care providers
   - ☐ Related to an appeal for benefits that has been denied
   - ☐ Other: _____

4. Specific purpose of the disclosure, for example "To discuss benefits with the Trust Fund so I can better understand my benefits.":
   - ☐ At my request, **OR**
   - ☐ For the following reason: _____

5. This authorization will expire on (give a date or occurrence – for example, "Upon termination of enrollment in the health plan."):
   - ☐ Until I revoke in writing, **OR**
   - ☐ Until the following occurs: _____

II. Important Information About Your Rights

I have read and understand the following statements about my rights:

- This authorization is voluntary and I may refuse to sign it.
- I may revoke this authorization at any time prior to its expiration date by sending a written revocation notice to the Privacy Officer at 4160 Dublin Blvd, Suite 100, Dublin, CA 94502 or Privacy Fax: 925-833-7301. The revocation will not have any effect on any actions that the entity took before it received the revocation notice.
- I am not required to sign this authorization as a condition to receiving treatment or payment for health care; enrolling in a health plan; or establishing eligibility for benefits.
- The information that is used or disclosed pursuant to this authorization may be redisclosed by the receiving person or organization and, upon redisclosure, no longer be protected by federal privacy laws.

III. Signature of Individual or Personal Representative* making the request

_____ _____

Signature Date

Address: _____ Daytime Telephone: (___) _____ - _____

IV. *If the form is signed by a Personal Representative, complete the following information (a *personal representative is someone who has authority under applicable law to act on someone's behalf, such as a parent, guardian or durable power of attorney. Please submit a copy of such legal document, if applicable):*

Printed name of the participant's Personal Representative: _____

Relationship to the participant, including authority to act as Personal Representative: _____

Please return this form to: Privacy Officer, 4160 Dublin Blvd, Suite 100, Dublin, CA 94568 or Privacy Fax: 925-833-7301