

Connecticut Carpenters Health Fund Authorization to Disclose Protected Health Information

Name of Individual (Please Print)

Social Security Number

Address of Individual

ALL OF THE FOLLOWING PARTS MUST BE COMPLETED

PART I: Authorized Person(s)

I authorize the Health Fund to disclose the PHI identified in Part II of this Form to the following person or entity: (please designate no more than one person or entity and provide name and address as requested)

- Board of Trustees (Note: This covers Individual Trustees serving at time of disclosure)
- NERCC Council Rep. _____
- Attorney _____
- Other Person _____

Address of Authorized Attorney or Other Person: _____

PART II: Description of the information to be used or disclosed

I authorize the Health Fund to disclose PHI (including written, electronic, or oral information) to the person(s) identified in Part I 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.)

All Claims and Eligibility Information All Claims Information All Eligibility Information
 Specific Medical, Dental, Vision, or Other Claim for Health Benefits as described below:

Provider: _____ Date(s) of Service: _____
 Other (please be as specific as possible) _____

PART III: Purpose of use or disclosure

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

- | | |
|--|---|
| <input type="checkbox"/> Health care claims or appeals | <input type="checkbox"/> Coverage |
| <input type="checkbox"/> Payment for health care | <input type="checkbox"/> Eligibility for benefits |
| <input type="checkbox"/> Coordination of benefits | <input type="checkbox"/> Premiums and copayments |
| <input type="checkbox"/> Health care claim status | <input type="checkbox"/> Preauthorization |
| <input type="checkbox"/> Subrogation and reimbursement | <input type="checkbox"/> Personal |
| <input type="checkbox"/> Other event (please state what the event is): _____ | |

PART IV: Termination of Authorization

This Form is valid for one year from signing or, if earlier, until the date or event I have indicated below or until I cancel the Form by completing a separate Cancellation of Authorization Form or signing the Cancellation of Authorization section on page 2.

_____ (Date or event)

PART V: Acknowledgment and Signature

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 TO THE BENEFITS OFFICE.
- CANCELLATION WILL TAKE EFFECT AS OF THE CANCELLATION DATE OR EVENT, OR ONCE THE BENEFITS OFFICE 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 OR PROTECTED HEALTH INFORMATION.
- THE HEALTH FUND WILL PROVIDE A COPY OF THIS SIGNED AUTHORIZATION FORM TO ME.

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 have a Personal Representative Form on file with the Fund Office.

PART VI: Witness or Attorney/Notary (Complete one)

Witness (Fund Office employee or Trustee only)¹

Signature

Date

(Print name)

OR

Commissioner of the Superior Court/Notary Public

Personally appeared before me at _____, Connecticut, this ____ day of _____, 20__, the within named _____, who acknowledged that signing this Authorization Form was his or her free act and deed.

Commissioner of the Superior Court

Notary Public

Notary Public commission expires: _____

Cancellation of Authorization (to be effective only after received by the Fund)

I hereby cancel my authorization to disclose protected health information to _____ effective immediately or as of _____.

Signature

Date

¹ A member of the Fund Office staff or a Trustee may witness the signature in person. Any signature not witnessed by Fund Office staff or a Trustee must be notarized or attested by a Commissioner of the Superior Court.