**DISCLOSURE FORM MUST BE COMPLETED IF HARDSHIP APPLICATION IS FOR MEDICAL BILLS.**

Dear Participant:

In order to comply with recently enacted legislation governing Health Insurance, HIPAA Privacy Rules requires that you sign an authorization form in order for the Annuity Fund to obtain information relevant to your Annuity Hardship withdrawal for medical bills.

To avoid delay in processing your application, please sign the enclosed form, as soon as possible, naming Annuity Fund Personnel as "Other Person". A self-addressed envelope is enclosed for your convenience.

Thank you for your cooperation in this matter.

Sincerely,

The Connecticut Carpenters Annuity Fund

# 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 Annuity Fund Personnel

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):**

__Health care claims or appeals
__Payment for health care
__Coordination of benefits
__Health care claim status
__Subrogation and reimbursement
__Coverage
__Eligibility for benefits
__Premiums and copayments
__Preauthorization
__Personal
__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.