Connecticut Carpenters Health Fund
Authorization to Disclose Protected Health Information

_____ _____
Name of Individual (Please Print) Identification 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:
(please designate no more than one person and fill in his/her name and address)

- ❑ Fund Trustee or NERCC Council Rep. _____
- ❑ Attorney _____
- ❑ Other Person _____

Address of Authorized 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 Notary (Complete one)

Witness (Fund Office employee or Trustee only)[1]

_____ _____

Signature Date

_____ (Print name)

OR

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.

_____

Notary Public
My commission expires: _____

<u>Cancellation of Authorization</u> (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.