Welfare Fund
PHI Authorization Form

A B C D E F G H I J K L M N

PLUMBING INDUSTRY BOARD
PLUMBERS LOCAL UNION No.1

50-02 5th Street, Long Island City, New York 11101
Tel. (718) 835-2700

(For Use or Disclosure of Protected Health Information)

Use a ballpoint pen to complete form

PURPOSE OF THIS FORM

The U.S. Department of Health and Human Services has issued regulations establishing strict standards on how health plans may use and disclose your medical records. In order for the Plumbers Local Union No. 1 Welfare Fund ("Fund") to use or disclose your Protected Health Information to someone other than you, you must complete this Authorization Form and return it to the Fund.

Protected Health Information ("PHI") is information that is created, received, transmitted or stored by the Fund which relates to your past, present, or future physical or mental health, health care, or payment for health care, and either identifies you or provides a reasonable basis for identifying you. Except as permitted by law, the Fund may not use or disclose PHI to persons other than those you specify on this form.

The Fund may request that you complete this form where the use or disclosure of information is necessary to carry out functions of the Fund. In addition, you may submit this form to the Fund because you want someone to request or receive your PHI from the Fund. This form is not needed if you are requesting your own PHI from the Fund. The Fund has a separate form for that type of request.

(A) Request for Plumbers Local Union No.1 Welfare Fund to Disclose Protected Health Information for

[redacted] [redacted] [ ][ ][ ][ ]
(1) Identification Number

_____ _____ _____
(2) Last (3) First (4) Init.

Your relationship to Member(5) ☐ Self ☐ Spouse ☐ Dependent ☐ Other _____

(B): Authorized Person *(Please print name)*

I authorize the Fund to disclose my protected health information (PHI) identified in **Part (C)** of this form to the following person: ***(please designate no more than one person and fill in their name and address)*** (1)

☐ Spouse ☐ Union Representative ☐ Attorney ☐ Other Person _____
Relationship

_____ _____ _____ (_____)_____-_____
Last Name(2) First Name(3) Init.(4) Telephone Number(5)

_____ _____ _____ _____
Street(6) City(7) State(8) Zip(9)

(C): Description of the information to be used or disclosed

I authorize the Fund to disclose my protected health information (PHI) (including written, electronic, or oral information) to the person identified in **Part (B)** of this form in connection with:***(If you want different people to have access to different information, you must fill out separate forms.)***

☐ All claims information for benefits covered under the Plan

☐ Specific Medical, Mental Health, Dental, Vision, Prescription Drug or Other Claim for Health Benefits
Provider: _____ _____
Date(s) of Service: _____

☐ Other (please be as specific as possible) _____ _____

_____

(D): Purpose of use or disclosure

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

☐ For any purpose	☐ Health care claims or appeals	☐ Payment for health care
☐ Coordination of benefits	☐ Health care claim status	☐ Coverage
☐ Eligibility in the Fund	☐ Premiums and copayments	☐ Preauthorization
☐ Subrogation and reimbursement	☐ I am requesting disclosure of PHI for my own purposes.	

☐ Other purpose (explain): _____

(E): Effective Period of the Form

This Authorization Form is valid for the period designated below:

☐ For as long as I am eligible for benefits under the Plan;
☐ Only until the information requested on this Form is provided to the individual identified on this form.
☐ Until _____(please provide a date or event);
☐ Until I cancel it by submitting a Cancellation of Authorization Form.

You may also cancel this authorization at any time, no matter which option you select above, by submitting to the Fund Office a properly completed Cancellation of Authorization Form. This Authorization is valid for one year from the date I sign this form unless I cancel the form or specify another date or event above.

(F): Acknowledgment and Signature

I understand that:

- **I HAVE THE RIGHT TO REVOKE THIS FORM AT ANY TIME BY SUBMITTING A CANCELLATION OF AUTHORIZATION FORM TO THE FUND.**
- **CANCELLATION WILL TAKE EFFECT AS OF THE CANCELLATION DATE OR EVENT, OR ONCE THE FUND RECEIVES THE CANCELLATION OF AUTHORIZATION FORM.**
- **THE PERSON I AM AUTHORIZING TO RECEIVE MY PHI MAY NOT BE REQUIRED TO TREAT THIS INFORMATION AS CONFIDENTIAL.**
- **THE FUND WILL PROVIDE A COPY OF THIS SIGNED AUTHORIZATION TO ME.**
- **I HAVE THE RIGHT TO REFUSE TO SIGN THIS AUTHORIZATION FORM.**

_____ _____

Your Signature (or Signature of Personal Representative*)[(1)] Date[(2)]

*If you are acting as the Personal Representative of the individual whose PHI is to be disclosed, you must provide proof of your authority to act for that individual.

Fund Office Use Only Date Mailed: _____ Processed By: _____ Status: _____

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