International Union of Operating Engineers
Local No. 478 Health Benefits Fund
Authorization to Disclose Protected Health Information (PHI)

Name of Individual (Please Print) _____ Member ID _____

Address of Individual _____ Phone Number _____

ALL OF THE FOLLOWING PARTS MUST BE COMPLETED

PART I: **Authorized Person(s)**
I authorize the Health Benefits Fund to disclose the PHI identified in Part II of this Form to the following person: (check only one (I) box below and provide name, phone number, email address and home address as requested)

☐ Spouse: _____

☐ Attorney: _____

☐ Other Person: _____

Home Address of Authorized Person: _____
Phone Number of Authorized Person: _____
Email of Authorized Person: _____

PART II: **Description of the information to be used or disclosed**
I authorize the Health Benefits Fund to disclose to the person identified in Part I of this Form:

☐ All of my PHI (including written, electronic, or oral information) and any information that relates to my claim for coverage or benefits under the Fund.

☐ Only the following PHI: _____

_____

PART III: **Acknowledgment and Signature**

I understand that:

- This authorization will remain in effect unless: (1) I revoke it; (2) it is superseded by a subsequent HIPAA Authorization Form; or (3) in the event my spouse is listed as an authorized person, the date the Fund Office receives written notification of our divorce from me or my former spouse.
- I have the right to revoke this HIPAA Authorization Form at any time by submitting a signed cancellation of authorization form to the health benefits fund office.
- If I do revoke the authorization I understand that it will not have any effect on any actions taken by the Health Benefits Fund prior to their receipt of the revocation.

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 properly completed Personal Representative Form on file with the Fund Office.

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

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

_____ _____
Signature Date