BEER INDUSTRY – LOCAL UNION NO.703

HEALTH & WELFARE FUND
18660 GRAPHIC DRIVE, SUITE 202- TINLEY PARK, ILLINOIS 60477-6260
Telephone: (708) 429-0046 Fax: (708) 429-0047

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Participant's Name: _____ _____SSN: XXX-XX-_____.
(Please Print)

Address: _____

Patient's Name: _____Telephone: _____ (Home__ Work) __

In the course of providing health plan coverage, the BEER INDUSTRY--LOCAL UNION NO. 703 HEALTH AND WELFARE FUND ("Fund") may obtain protected health information about you or your dependent child(ren). Except as permitted by law and Federal regulations, the Fund will not disclose that protected health information to any person or entity. If you would like another person to assist you in obtaining benefits from the Fund, you can sign this Authorization Form. The Fund WILL NOT condition payment of a claim, enrollment in a plan or eligibility for benefits on your decision to sign this Authorization Form. You are not required to sign this form.

This Authorization Form is only effective if it is signed by the person whose medical information is to be disclosed, or by someone authorized to sign for that person. If the person whose medical information is to be disclosed is a child under age 18, a parent living with the child can sign on behalf of the child.

"Authorized Person" means the person who you want to act on your behalf in dealing with the Fund with respect to your health claim(s). By filling in this form, you are giving the Fund permission to disclose your protected health information to the Authorized Person and you are advising the Fund how much information the Fund can provide to the Authorized Person.

1. **Name and Address of Authorized Person:** _____
_____

I understand that the Authorized Person (unless he/she is a health care provider) is not subject to Federal privacy standards and that disclosing my health information pursuant to this authorization creates a risk of redisclosure without my authorization.

2. **Description of Health Information to Be Used or Disclosed.** In order to enable the Authorized Person to assist me in obtaining benefits from the Fund, I want this authorization to apply to all information concerning medical treatment arising out of my illness and/or injury occurring on or about_____, 20__. This authorization allows the Fund to disclose and use any health information arising out of the above-described illness or injury, unless I specify otherwise on the following lines. This authorization does not apply to: (Specify any element or category of health information that relates to the above-described illness or accidental injury, but which you do NOT want to be disclosed.)

Also, this form does not authorize the disclosure, release or use of psychotherapy notes.

3. **Persons and Organizations Authorized to Disclose My Health Information.** This authorization applies to the Fund and to all of its employees, representatives and agents having access to my health information.

4. **Purpose of the Requested Use and/or Disclosure.** I authorize my health information to be used and/or disclosed for all purposes that Authorized Person deems necessary or advisable to assist me in obtaining benefits from the Fund.

5. **Your Rights with Respect to This Authorization.** You have the right to revoke this authorization at any time. Any revocation must be in writing, sent or delivered to the Fund at the address at the top of this form. A revocation will not be effective as to uses and/or disclosures of my health information that have already made in reliance upon this authorization prior to receipt of your written revocation. Also, if you sign this authorization, you will be provided with a signed copy of it.

6. **Expiration of Authorization.** Unless you insert a date on the following line or provide a written request, this authorization will not expire.

This authorization will expire on (date): _____20___

7. **Authorization.** By signing this Authorization Form, I authorize the Fund and its agents and employees to disclose my health information, subject to the limitations contained in this Authorization Form. I understand that I am under no obligation to sign this form. I have signed this form voluntarily to document my wishes regarding the use and/or disclosure of the health information described on this form. I have had an opportunity to review, and I understand the contents of, this form.

_____

Signature Print Name Date

If authorization is signed by on behalf of another person, please complete the following.

Name of person _____. Relationship or nature of authority (for example, signer is a parent or guardian or has health care power of attorney:

_____