Authorization for Release of Protected Health Information

The "Plan" as referred to on this form is the Pipe Fitters Local No. 533 Health Care Plan.

PARTICIPANT

I, (Print Name) _____, (Participant Social Security #) _____ authorize the Plan, and its business associates, to disclose claims, payment, eligibility and other related health information about me to the following persons (select 1-2 persons if desired), at the request of such persons:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I have read and understand the section of this form entitled **Expiration, Revocation, and Redisclosure.**

Signature of Participant _____**Date Signed**_____

-OR-☐ I do not want my Health Information released to anyone but myself.
Signature of Participant_____ **Date Signed**_____

SPOUSE SECTION

I, the Spouse (Print Name) _____, (Spouse's Social Security #) _____ of the above-named Participant authorize the Plan to disclose claims, payment, eligibility, and other related health information about me to the following persons (select 1-2 persons desired), at the request of such persons:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I have read and understand the section of this form entitled **Expiration, Revocation, and Redisclosure.**

Signature of Spouse _____ **Date Signed** _____

-OR-☐ I do not want my Health Information released to anyone but myself.
Signature of Spouse_____ **Date Signed**_____

DEPENDENT(S) OVER THE AGE OF 18 SECTION- copy and submit one form for each.

I, (Print Name) _____, (Social Security #) _____ , a dependent of the above Participant, am over the age of 18 and authorize the Plan to disclose claims, payment, eligibility, and other related health information about me to the following persons (select 1-2 persons desired), at the request of such persons:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I have read and understand the section of this form entitled **Expiration, Revocation, and Redisclosure**.

Signature of Dependent _____ **Date Signed** _____

-OR-☐ I do not want my Health Information released to anyone but myself.
Signature of Dependent_____ **Date Signed**_____

Expiration, Revocation, and Redisclosure

I understand that this authorization will remain in effect for one year following my termination of coverage unless I revoke it sooner. I understand that I have the right to revoke it at any time, except to the extent that it has already been relied upon, I understand that if I decide to revoke this authorization, I must give notice of my decision in writing and send it to: **Pipe Fitters Local 533 Health Care Plan, ATTN: HIPAA, 8600 Hillcrest Road, Suite A, Kansas City, MO 64138**

I understand that my health information that is disclosed pursuant to this authorization may be redisclosed by the persons I have identified above, and the Plan cannot prevent or protect such redisclosures, AND I understand that I am not required to sign this form to receive my health care benefits (enrollment, treatment or payment).