Pipe Fitters Local No. 533 Health and Welfare Plan

8600 Hillcrest Road, Suite A | Kansas City, Missouri 64138 | (p) 816.361.0206 | (f) 816.444.4275

DESIGNATION OF AUTHORIZED REPRESENTATIVE AND PROTECTED HEALTH INFORMATION AUTHORIZATION FORM

Section A: Individual Authorizing Use or Disclosure

Full Name _____ Social Security Number _____

( ) _____ ( ) _____

Telephone Number (Daytime) Telephone Number (Evening)

Street Address _____ Apt/Lot # _____

City _____ State _____ Zip _____

Instructions

The Pipe Fitters Local No. 533 Health and Welfare Plan ("Plan") is required to and will Disclose your Protected Health Information (PHI) to you or your personal representative upon written request. In addition to Disclosure of your PHI to you and your personal representative, the Plan will also, generally, Use and Disclose your PHI in accordance with the direction and authorization you provide in Sections B and C of this form.

A claim or appeal may be filed on your behalf by your authorized representative. To designate an authorized representative please complete Section D of this form. Due to the information typically involved with a claim or appeal, it is necessary to direct and authorize the Plan to Disclose your PHI to your authorized representative. Therefore, when designating an authorized representative (Section D), it is required that Sections B and C also be completed.

Section B: Scope of Authority

I understand that my PHI may include, but is not limited to, the following: medical records, emergency care records, billing statements, Explanation of Benefits, diagnostic imaging reports, transcribed hospital reports, laboratory reports, dental records, pathology reports, physical therapy records, hospital records (including nursing records and progress notes), claim status, claim information, confirmation or denial that treatment has occurred, treatment information, information on my physical or mental condition, and any personal or medical information related to the purpose of this authorization. I further understand that my PHI may include information related to any of the following: genetic testing, mental health (excluding psychotherapy notes), HIV/AIDS, prescription medication, pregnancy, maternity, organ transplants, and chemical dependency (including alcohol and drug treatment).

Please list the PHI items that you are authorizing the Plan to Use or Disclose, and any conditions or limitations (if you do not identify any items, conditions or limitations, the Plan will assume it may Use or Disclose all of your PHI to the persons/organizations named in Sections C and D, with no conditions or limitations). I authorize the Use and/or Disclosure of the following PHI:

_____

_____

_____

Section C: Persons/Organizations Authorized to Use or Disclose My PHI

The Pipe Fitters Local No. 533 Health and Welfare Plan is authorized to release my PHI.

The following individuals or organizations are authorized to **RECEIVE** my PHI **(you MUST include your relationship to the recipient and the recipient's address and telephone number)**:

_____

_____

_____

_____

I understand that this authorization will expire on the following date: _____ **OR** upon the occurrence of the following event (e.g., termination as a Covered Person in the Plan): _____

_____, whichever comes first.

Section D: Designation of Authorized Representative (Sections B and C must be completed if designating an authorized representative)

I hereby appoint _____ (name of authorized representative) to act on my behalf in connection with my claim(s) and appeal(s) for benefits under the Pipe Fitters Local No. 533 Health and Welfare Plan. I authorize my representative to receive any and all information that is provided to me and to act for me in providing any information to the Plan that relates to my claim(s) and appeal(s) for benefits under the Plan. All information and notifications from the Plan will be directed to the authorized representative through this form.

I understand that this authorization will expire on the following date: _____ **OR** upon the occurrence of the following event (e.g., termination as a Covered Person in the Plan): _____

_____, whichever comes first.

Section E: Terms and Conditions of this Authorization

I understand that I may refuse to sign this authorization. I understand that the Plan may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization. I further understand that if the person(s)/organization(s) authorized to receive my PHI are not health plan or health care providers, the Disclosed information may no longer be protected by federal privacy regulations and information Disclosed pursuant to this authorization may be subject to re-Disclosure by the recipient. I also understand that I may revoke this authorization at any time by sending a written request for revocation to the Fund Office. A request for revocation will become effective on the date that it is received by the Fund Office. Unless revoked earlier, this authorization will expire on the date or event specified above in Section C and/or Section D.

Section F: Purpose of Authorization

Purpose for which Use or Disclosure is authorized (NOTE: You are not required to provide a specific purpose; if left blank, the Plan will presume that the Use or Disclosure is simply being made at your request):

_____

_____

SECTION G: Signature

Signature Date

If this authorization is signed by a personal representative on behalf of the Covered Person, please complete the following:

Personal Representative's Name

Relationship to the Covered Person (e.g., parent, guardian, *or attorney-in-fact*)

** Please attach documentation demonstrating that you have the authority to act on the Covered Person's behalf (for example, power of attorney).

Please return completed and signed form to the following address:

Pipe Fitters Local No. 533 Health and Welfare Plan
8600 Hillcrest Road, Suite A
Kansas City, Missouri 64138

If you have questions, or need additional information or assistance in completing this form, please contact us at the above address or at (816) 361-0206.