# INSTRUCTIONS FOR COMPLETING AN AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

As you may know, pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), the Fund cannot disclose information or documentation (such as information on your claims or your history as a participant or beneficiary of the Fund) containing your protected health information without your written authorization. If you would like the Fund to disclose your protected health information, you need to complete the Fund's HIPAA Authorization From and return it to the Fund office so that we may provide your protected health information directly to the party whom you identify on this form. (NOTE: If someone is completing this form on your behalf, as your personal representative, you must also provide documentation confirming that the individual who completed the form is authorized to represent you.) Listed below are specific instructions on how to complete this form:

- Section 1 is to be completed by you (or by your personal representative, as described above) since your protected health information will be provided to the designated party named in Section 2.

- Section 2 is the name of the party, and their relationship to you, to whom your protected health information can be provided.

- Section 3 should list the specific information that can be provided to the party named in Section 2. (If you intend to authorize the Fund to disclose your protected health information only as it pertains to particular claims or events, you should state that restriction in Section 3 when you describe the information that you are authorizing the Fund to provide to the designated party. Your description of that information should also include the date(s) of service for the claim(s) or event(s) in question.)

- The items in Section 4 should only be initiated if they pertain to the claim(s) or event(s) described in Section 3 and you wish information pertaining to the items in Section 4 to be provided to the designated party. Authorization to provide information on these matters to the designated party is optional.

- Section 5 (on page 2 of the Authorization Form) should be completed as indicated on the Authorization Form. You are free to choose any date that you wish. However, we ask that it be a maximum of two years.

Please note that if we do not receive the completed Authorization Form signed by you (or your personal representative), or if we receive the form and it is incomplete or not properly completed, we cannot disclose any information or documentation containing your protected health information to any other parties.

Please complete the form and return it via fax to Edee McKee at (610) 941-5325 ext. 103 or by first class mail to the Fund office at 3031B Walton Road, Plymouth Meeting, PA 19462.

If you (or your personal representative) have any questions regarding how to complete the Authorization Form, please do not hesitate to contact Edee McKee at the Fund office at (610) 941-9400, ext. 103, by fax at (610) 941-5325 or by e-mail at EMcKee@ufcw1776benefitfunds.org.

UFCW LOCAL 1776 AND PARTICIPATING EMPLOYERS
HEALTH AND WELFARE FUND

AUTHORIZATION FORM
(Please complete all information)

By signing and submitting this form, I am authorizing the UFCW Local 1776 and Participating Employers Health and Welfare Fund ("the Fund") to disclose my protected health information (that is, information in the Fund's files about me, the medical treatment I have received and the payment status of claims for this medical treatment) to the person identified below. I understand that this authorization is voluntary and that I can revoke it at any time by informing the Fund in writing that I am revoking this authorization.

**SECTION 1**

_____
Name of Participant or Dependent (Print or Type)

Address:_____

_____

Social Security Number _____

_____
Signature of Participant or Dependent

Date

Home Phone _____ E-mail_____

Work Phone_____

**SECTION 2**

I authorize the UFCW Local 1776 and Participating Employers Health and Welfare Fund to disclose the information described in **Section 3** to the person or organization listed below (for example, Gladys Smith):

_____
Name of person/organization

_____
Name of person/organization

_____
Relationship of Authorized Individual to Participant or Dependent
(for example, my mother)

**SECTION 3**

I authorize the UFCW Local 1776 and Participating Employers Health and Welfare Fund to disclose the information described below to my authorized representative (for example, the reasons that my claim for physical therapy benefits were denied).

_____

_____

**SECTION 4**

The UFCW Local 1776 and Participating Employers Health and Welfare Fund needs your **specific authorization** to release protected health information pertaining to the items listed below. An authorization for psychotherapy notes cannot be used for any other type of information. By initialing, I authorize release of the information pertinent to my case:

Psychotherapy Notes

_____
(*Initials*)

Mental/Behavioral information

_____
(*Initials*)

Chemical dependency (*includes Alcohol/drug treatment)* _____ (*Initials)*

HIV/AIDS

_____
(*Initials)*

**SECTION 5**

**Expiration Date of Authorization**
This authorization is effective through ____/___ /____ unless revoked or terminated by me or my personal representative.

**Right to Terminate or Revoke Authorization**
You may revoke or terminate this authorization by submitting a written revocation to the UFCW Local 1776 and Participating Employers Health and Welfare Fund to terminate this authorization.

**Potential for Redisclosure**
Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under the federal privacy regulations.