INSTRUCTION SHEET FOR HIPAA AUTHORIZATIONS

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

The name of the person whose PHI is going to be disclosed is to be printed in the space provided.

The check box "Myself" should be checked.

ONLY FOR A MINOR CHILD: If the information to be disclosed is for a minor child and the information will be disclosed to someone other than the parent, that check box should be checked and the child's name and Social Security Number should be filled in. Example: If a Union Representative is going to help resolve a benefit or claim for a minor child, this box should be checked. The parent does NOT have to have the minor child fill out an authorization. In most cases the parent has authority to act on behalf of the child and have access to the child's PHI.

HEALTH INFORMATION TO BE DISCLOSED "AT THE REQUEST OF THE INDIVIDUAL"

This section is used to describe the protected health information (PHI) is to be disclosed. Dates can be used to describe eligibility, benefits or claims in dispute.

Example: Eligibility, benefits or claims in dispute between January 1, 2003 and December 31, 2003.

In the case of a participant giving their spouse access to protected health information, the "Other" box can be checked with the statement such as:

"Any and all information that may be requested by my spouse concerning my benefits, eligibility or claims status."

Be sure to complete the address information.

*** THIS SECTION HAS TO BE COMPLETED ***

DISCLOSED TO

This section is used to describe the person or entity that the information is going to be disclosed to.

Example: If to the spouse, put spouse's name and relationship.

Example: If to a Union Representative, put the Representative's name down with the title, Union Representative.

Example: If to the Local Union, The Office Staff of Local Union No. 000.

*** THIS SECTION HAS TO BE COMPLETED ***

AUTHORIZATION EXPIRATION

The Authorization has to have an expiration date or event.

A specific expiration date can be entered.

The check box, "Until eligibility / benefits have been resolved" can be used.

The "Event" check box can be used with the statement: *"Two year after the termination of eligibility."*

*** THERE HAS TO BE AN EXPIRATION DATE OR EVENT ***

SIGNATURE

The Authorization has to be signed and dated. It will not be valid without a signature, SS# and date.

*** SIGN AND DATE ***

REVOCATION

DO NOT SIGN THIS SECTION AT THIS TIME. If you want to revoke this Authorization at a later date, this Section can be signed and returned. You should retain a copy of this authorization or request that a copy is returned to you.

SAMPLE FORM

FUND NAME
Authorization for the Disclosure of Protected Health Information
13191 Crossroads Parkway North, Suite 205, City of Industry, CA 91746-3434
Privacy Official FUND PHONE AND FAX NUMBER

As required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) the Administrative Office may not use or disclose your health information except as provided in our Notice of Privacy Practices without your authorization. Your signature on this form indicates that you are giving permission for the uses and disclosures of Protected Health Information (PHI) described herein. You may revoke this authorization at any time by signing and dating the revocation section on your copy of this form and returning it to this office.

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

I, John Doe (print name) hereby authorize the Administrative Office Staff to make the following disclosures of my health information that pertains to:

☒ Myself

☐ My dependent child/ren. Name and SS#: ____________

HEALTH INFORMATION TO BE DISCLOSED "AT THE REQUEST OF THE INDIVIDUAL"

☐ Information pertaining to eligibility and/or benefits between (date) ____________ and (date) ____________

☒ Other: Any and all information that may be requested by my spouse concerning my benefits, eligibility or claims status

DISCLOSED TO

☒ I further authorize the following person(s) or entity to receive these disclosures of my health information:

Name: Jane Doe Title/Relationship: Spouse

Address: 123 Main St

Any Town USA

Phone: (000) 000-0000 Fax: ____________

AUTHORIZATION EXPIRATION

I understand that this authorization will automatically expire (enter date or event):

☐ Date: ____________

☐ Until eligibility / benefits in dispute have been resolved.

☒ Event: Two years after termination of eligiblity

SIGNATURE

Signed: *John Doe* Date: 00/00/00

Social Security Number: 000-00-0000

If not signed by the participant, please indicate relationship: ____________

Print Member Name: John Doe Member SS#: 000-00-0000

REVOCATION

☐ I hereby revoke this authorization.

Signature: ____________ Date: ____________

A COPY OF THIS AUTHORIZATION IS TO BE GIVEN TO THE PARTICIPANT

I understand that information disclosed pursuant to this authorization may potentially be re-disclosed by the recipient to additional parties and no longer protected by the Privacy Rule.

I understand that I may revoke this authorization at any time by signing the revocation section of my copy of this form and returning it to the Administrative Office. I further understand that any such revocation does not apply to the extent that persons authorized to use or disclose my health information have already acted in reliance on this authorization.

I understand that I am under no obligation to sign this authorization. I further understand that my ability to obtain treatment, payment, enrollment or eligibility for benefits will not depend in any way on whether I sign this authorization.

I understand that I have a right to inspect and to obtain a copy of any information disclosed pursuant to this authorization. This authorization will be valid only when all sections are completed.

Office and Professional Employees Locals 30 & 537 Health & WelfareFund

Authorization for the Disclosure of Protected Health Information

13191 Crossroads Parkway North, Suite 205, City of Industry, CA 91746-3434
Privacy Official (562) 463-5065 • (800) 386-4350 • Fax (562)463-5994

As required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) the Administrative Office may not use or disclose your health information except as provided in our Notice of Privacy Practices without your authorization. Your signature on this form indicates that you are giving permission for the uses and disclosures of Protected Health Information (PHI) described herein. You may revoke this authorization at any time by signing and dating the revocation section on your copy of this form and returning it to this office.

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

I, ______________________________ (print name) hereby authorize the Administrative Office Staff to make the following disclosures of my health information that pertains to:

☐ Myself

☐ My dependent child/ren. Name and SS#: ______________________________

HEALTH INFORMATION TO BE DISCLOSED "AT THE REQUEST OF THE INDIVIDUAL"

☐ Information pertaining to eligibility and/or benefits between (date) ______________ and (date) ______________

☐ Other: ______________________________

DISCLOSED TO

☐ I further authorize the following person(s) or entity to receive these disclosures of my health information:

Name: ______________________________ Title/Relationship: ______________

Address: ______________________________

____

Phone: ______________________________ Fax: ______________________________

AUTHORIZATION EXPIRATION

I understand that this authorization will automatically expire (enter date or event):

☐ Date: ______________

☐ Until eligibility / benefits in dispute have been resolved.

☐ Event: ______________________________

SIGNATURE

Signed: ______________________________ Date: ______________

Social Security Number: ______________________________

If not signed by the participant, please indicate relationship: ______________________________

REVOCATION

☐ I hereby revoke this authorization.

Signature: ______________________________ Date: ______________

A COPY OF THIS AUTHORIZATION IS TO BE GIVEN TO THE PARTICIPANT

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