

BOILERMAKERS NATIONAL HEALTH AND WELFARE FUND

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

If you do not want your Protected Health Information released to another person or entity except as allowed by law or as permitted by the Plan, **TAKE NO FURTHER ACTION AND DO NOT COMPLETE AND RETURN THIS FORM TO THE BOILERMAKERS NATIONAL HEALTH AND WELFARE PLAN OFFICE.** The Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule requires that this form be completed if you want the Boilermakers National Health and Welfare Fund to be able to release your Protected Health Information (PHI) to another person.

I authorize Boilermakers National Health and Welfare Fund to use or disclose my protected health information as specified below.

1. PATIENT INFORMATION

The patient is the individual who the information (such as medical claims and enrollment) is about.

Name of Patient _____
(please print)

Social Security Number _____

2. PARTICIPANT/RETIREE INFORMATION

Fill out the Participant/Retiree information if the patient and the Participant/Retiree are not the same person.

Name of Participant/Retiree _____
(please print)

Social Security Number _____

3. PERSON AUTHORIZED TO RECEIVE THE INFORMATION

Fill out the information about the person(s) to whom you want your information disclosed.

Name of person(s) authorized to receive this information: _____

Address _____

Phone Number _____

4. RESTRICTIONS AND PURPOSE

Complete the first OR second item or leave both items blank. If you leave both the first and second items blank, you are authorizing the health plan to disclose any or all PHI that it holds.

This authorization is limited only to the following information: _____
(For example, only information about a specific claim, eligibility, or some other limitation.)

This authorization covers all PHI held by the health plan except: _____
(For example, everything except information related to a certain diagnosis or some other specific exception.)

5. THE PURPOSE OF THIS AUTHORIZATION IS: _____

You do not need to state a purpose. If you do not state a purpose, the purpose will be deemed to be at your request.

6. EXPIRATION DATE OR EVENT.

If you leave this section blank, the expiration event will be deemed to be when revoked in writing by you or your personal representative.

I want this authorization to expire:

In two years.

Upon termination of enrollment in the health plan (this authorization remains in effect until revoked by my personal representative or me).

On another date or event *(please specify)*. _____

7. PATIENT'S ACKNOWLEDGEMENT AND SIGNATURE

Read the acknowledgement and sign and date the form in the Patient's Acknowledgement and Signature section.

I acknowledge that I have read and understand what information is covered by this authorization, and that I understand: (1) that I may revoke this authorization at any time; (2) that my revocation of this authorization may not cover any disclosures that were already made in reliance on this authorization before the Fund receives my revocation; (3) that I do not give up any rights to treatment, payment, enrollment, or eligibility for benefits based on whether I sign or refuse to sign this form; and (4) that once my information has been disclosed according to this authorization, the information may no longer be protected, and the recipient named in item 3 above may be able to further disclose the information.

I understand that my PHI may include, but is not limited to, the following: any legal documents, eligibility or enrollment information, demographics, 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).

Patient's signature _____

Date signed _____

REPORTING OF PERSONAL REPRESENTATIVE INFORMATION

Complete the Personal Representative Information section **ONLY** if "The Patient" has already legally designated someone to act as their Personal Representative in medical benefits-related matter, such as a Power Of Attorney, Medical Power of Attorney, or some other legal authority to act on their behalf. Be sure to attach a copy of the legal documentation that provides this authority.

1. PATIENT INFORMATION

"The Patient" is the individual who the information (such as medical claims and enrollment) is about.

Name of Patient _____
(please print)

Social Security Number _____

2. PARTICIPANT/RETIREE INFORMATION

Fill out the Participant/Retiree information if the patient and the Participant/Retiree are not the same person.

Name of Participant/Retiree _____
(please print)

Social Security Number _____

The person named below has been designated to act legally on behalf of "The Patient" in matters concerning the group health plan. "The Patient's" Protected Health Information may be disclosed to this person. Attached is a copy of a document that shows this person is legally permitted to act as the Personal Representative of "The Patient".

Name of Personal Representative _____ Relationship _____

Address of Personal Representative _____

Phone number of Personal Representative _____

Signature of Personal Representative _____

The following forms or documents are available by contacting the Boilermakers National Funds Office of Privacy Practices, 754 Minnesota Avenues, Suite 522, Kansas City, KS 66101-2766, phoning toll free 866 - 342-6555, or faxing 913 - 342-5751:

- Revocation of Authorization
- Request for Restrictions of Uses and Disclosures of PHI
- Request for Confidential Communications
- Request for Access to PHI
- Request for Amendment to PHI
- Request for Accounting of Disclosures of PHI
- Complaint Form