

(Pay special attention to the **SHADED** areas.)



AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

754 Minnesota Avenue, Kansas City, KS 66101-2766
Phone: 866-342-6555
Customer Care Fax: 913-342-0242

Subrogation ___ Worker Compensation ___ Appeal ___ Own Records ___ Other _____

Name of Patient: _____
Last 4 digits of Social Security Number: _____

Name of Participant: _____
Last 4 digits of Social Security Number: _____

I. Information About the Use or Disclosure: I hereby authorize the use or disclosure of my protected health information ("PHI") as described below.
Purpose: _____

II. Person/organization authorized to provide the information: Boilermakers National Health and Welfare Fund

III. Person/organization authorized to receive the information:

Name: _____ **Relationship to Participant:** _____
Address: _____ **Phone:** _____

IV. Restrictions: If records are sought for more than a 5 year time period, please contact the Fund to discuss the scope of the request so as to facilitate timely provision of access.

___ The Fund is authorized to release records from (date) _____ to (date) _____
___ This authorization is limited to only the following information: _____
___ This authorization covers *all* PHI held by the Fund except: _____

V. This authorization expires: _____ (list a date or event for expiration)

VI. Important Information About Your Rights: I have read and understood the following statements about my rights:

- I may revoke this authorization at any time by notifying the Fund Office in writing, but the revocation will not have any effect on any actions that the Fund took before it received the revocation.
- I may see and copy the information described on this form if I ask for it.
- I am not required to sign this form to receive my health care benefits (enrollment, treatment, or payment).
- The information that is used or disclosed pursuant to this authorization may be redisclosed by the receiving person/entity. I have the right to seek assurances from the above-named persons/organizations authorized to receive the information that they will not redisclose the information to any other party without my further authorization.

See the Fund's Privacy Notice for more information about your rights. For a copy contact the Office of Privacy Practices, Boilermakers National Funds, 754 Minnesota Avenue, Kansas City, KS 66101-2766, (866) 342-6555, or go to www.bnf-kc.com.

VII. Signature of Individual or Individual's Representative:

(Signature of Individual or Individual's Representative) _____

(Printed name of the Individual or Representative) _____

Date: _____ **Address:** _____

Relationship to Individual: _____ **Phone Number:** _____

If you are signing as personal representative of the individual named above and we do not have an authorization on file permitting us to release the Individual's PHI to you, **you must include** a copy of the Power of Attorney, Conservatorship letters or Guardianship letters that authorize you as Representative to release PHI.