

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Participant /Dependent Name _____ Policy ID Number _____

I authorize the use or disclosure of the above-named person’s protected health information, as described below. I understand this authorization is voluntary, and I further understand that any information released under this authorization will no longer be protected by federal privacy regulations, and may not be protected under applicable state privacy laws.

I authorize the following person(s)/organization(s) to provide the information:

Tri-State Carpenters & Joiners Health and Welfare Trust Fund

I authorize the following person(s)/organization(s) to receive the information:

The specific type and amount of information to be used and/or disclosed, including date(s) is:

Any and all dates and information having to do with coverage or payment of claims for me or my dependents

This information is being disclosed for the following purpose(s):

To assist in payment of claims or continuation of coverage

Will the health plan or health care provider requesting the authorization receive financial or in-kind compensation in exchange for using and/or disclosing the information released under the authorization?

Yes ___ No X

I understand that I have the right to revoke this authorization at any time by submitting a written revocation to **Tri-State Carpenters Health & Welfare Fund, PO Box 1208, Chattanooga, TN 37343**. I understand that the revocation will not apply to information already released under this authorization. **This authorization will remain in effect until such time that I send in said written revocation.**

I understand that my health care, payment for health care, or enrollment or eligibility of group health benefits under the Tri-State Carpenters Health & Welfare Fund group health plan will not be affected if I do not sign this authorization. Further, I understand that I may see and copy the information described on this authorization if I ask to do so. I have made a copy of this signed authorization for my records.

Signature of Participant/Beneficiary/Dependent or Personal Representative*:

Date: _____

Printed Name of Participant/Beneficiary or Personal Representative*:

****Form documenting representative status must be submitted before signing this authorization.***

****YOU MAY REFUSE TO SIGN THIS AUTHORIZATION****