Authorization for the Use and Disclosure of Protected Health Information

PLEASE READ THIS DOCUMENT CAREFULLY

This is an authorization form that will permit the UMWA Health and Retirement Funds (the Funds) to use or disclose some of your protected health information. The Funds will not condition your enrollment, eligibility, or payment of benefits on whether you sign this authorization. You have the right to revoke (or cancel) this authorization at any time by sending a written revocation to Privacy Officer, UMWA Health and Retirement Funds, 2121 K Street, N.W., Suite 350, Washington, D.C. 20037. Your revocation will not apply, however, to uses and disclosures the Funds has already made in reliance on your authorization.

1. I, ______________________________ ______________________________

Name of Patient *Health Services ID Number*

of ____

Patient's Address

authorize the Funds to use and disclose the following specific health information about me (for example, eligibility, payment or medical management records):

____

List specific health information that may be used or disclosed

2. I authorize the Funds to disclose the specified health information to the following entity or persons (state name and address of person or entity):

____

Name of person or entity authorized to receive my health information *Phone Number*

____

Address *City* *State* *Zip Code*

3. This use or disclosure is for the following purpose or purposes:

____

____

4. This authorization is in effect:

   a. from ___/___/___to ___/___/___; or

   b. from ___/___/___ until the occurrence of the following event (for example, death, termination of litigation):

____

Event

5. If you are not the patient and you are authorizing the use and disclosure of health information, please describe your authority (for example, legal guardian, legally authorized representative, parent of minor child) to request, use or disclose the protected health information:

____

Authority to Represent Patient (if necessary)

6. I understand that:

- ❖ This authorization is voluntary and that I may refuse to sign it, and that the Funds may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization.
- ❖ I may revoke this authorization at any time by sending a request to the Privacy Officer at the address provided above, except to the extent that the Funds already has taken action based on this authorization.
- ❖ If this authorization is obtained as a condition of obtaining health benefits coverage, other laws may give the Funds the right to contest a claim under the health plan.
- ❖ I have a right to request and receive a Notice of Privacy Practices from the Funds.
- ❖ Information used or disclosed based on this authorization may be re-disclosed by the recipient, and that any such re-disclosure may not be protected by law.
- ❖ The Funds will use or disclose my health information as described above until this authorization expires.
- ❖ I will receive a copy of this authorization for my records.

____ ______________________

*Signature of patient or legal representative*** *Date*

____

Printed Name

** If signed by a legal representative, you must provide a copy of the legal documents authorizing you to receive the requested protected health information.**