Please tear off back copy and keep for your records.

UMWA Health & Retirement Funds
Authorization for the Use and Disclosure of Protected Health Information

This is an authorization form that will permit the UMWA Health & Retirement Funds (the "Funds") to use or disclose some of your medical information known as protected health information. This form is voluntary — the Funds may not condition your treatment, payment, enrollment, or eligibility for benefits on whether you sign this authorization.

Beneficiary Name _____

Health Services ID Number (if known) _____

Beneficiary Address _____

The Funds and its business associates may use and disclose the following specific health information about me (for example, eligibility, payment or medical management records, any):

The Funds and its business associates may disclose my protected health information to the following people or organizations:

Name	Address	Phone #
_____	_____	_____
_____	_____	_____
_____	_____	_____

Purpose of disclosure? _____

When may the Funds and its business associates share your protected health information?

Start date _____ ☐ Until my death ☐ Until (Specify date or event _____)

I understand the following:

- ❖ I may revoke this authorization at any time by sending a written request to Privacy Officer, UMWA Health & Retirement Funds, 2121 K Street NW Suite 350, Washington, DC 20037. (Revocation will not apply to actions taken in reliance on this authorization before the revocation.)
- ❖ Any protected health information disclosed pursuant to this authorization may be re-disclosed by the recipient, and this re-disclosure may not be protected by law. Protected health information disclosed pursuant to, but before I revoke, this authorization may not be protected if I revoke this authorization.
- ❖ I may request a copy of this authorization for my records.

Who is signing this form? ☐ Patient ☐ Representative (Describe authority* _____)

**Examples: power of attorney, executor of the estate, parent of a minor child. If you are a representative, you must provide copies of the legal documents authorizing you to receive the protected health information.*

Printed Name _____

Signature _____ Date _____

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