

AUTHORIZATION FOR RELEASE OF INFORMATION TO MY DESIGNATED REPRESENTATIVE

SECTION A: MUST BE COMPLETED BY THE PERSON WHO HAS INCURRED THE CLAIMS

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that NECA-IBEW Welfare Trust Fund is authorized to disclose information which is protected by federal privacy regulations.

Insured's Name: _____

Insured's Social Security Number: _____

Patient's Name: _____

Patient's Social Security Number: _____

Specific description (including date(s)) of Personal Health Information (PHI) to be used or disclosed (minimum necessary):

<u>Date(s) of Service</u>	<u>Provider(s)</u>	<u>Amount(s)</u>

Designated representative(s) to whom disclosure will be made:

Name of Representative Relationship

Name of Representative Relationship

Section B: NECA-IBEW has requested this authorization

- a. The purpose of the use or disclosure: to discuss your individually identifiable health information with the person you have named as having permission to make inquiries regarding your claims.

Section C: Must be completed by the person who incurred the claims or their representative (In the case of minor children)

You must read and initial the following statements for this authorization to be valid:

1. I understand that the payment for my health care will not be affected if I do not sign this form. **Initials:** _____
2. I understand that I may see and copy the information described on this form if I ask for it and that I receive a copy of this form after I sign it. **Initials:** _____
3. I understand that I may revoke this authorization at any time by notifying NECA-IBEW in writing, but if I do, it won't have any affect on any actions taken before NECA-IBEW received the revocation. **Initials:** _____
4. I understand I may terminate this authorization on a specific date or event (example: upon payment of this claim). This authorization will expire on ____/____/____ or _____ **Initials:** _____
5. I understand that information used by, or disclosed to, any entity other than a health plan or health care provider may no longer be protected by the federal privacy law. **Initials:** _____

Signature of authorizing party or their representative

Date: ____/____/____

*** For minor age children, the authorization will need to be signed by the father or the mother.**

FORM MUST BE COMPLETED BEFORE SIGNING!

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