

**PLUMBERS AND PIPEFITTERS LOCAL UNION NO. 172 WELFARE FUND  
AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION**

**Section A - Requesting an Authorization**

I authorize the use/disclosure of my protected health information as described in Section B below. I understand that this authorization is voluntary and the Plumbers and Pipefitters Local No. 172 Welfare Fund ("Fund") and entities with which the Fund has contracted to perform administrative duties ("Fund Entities"), will not condition treatment, payment, enrollment, or eligibility for benefits on receiving this authorization. If Fund Entities disclose this information, the recipient must obtain an additional authorization from me before it may re-disclose the information. Otherwise, information disclosed under this authorization may be re-disclosed by the recipient and no longer protected.

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_

Social Security Number: \_\_\_\_\_  
Telephone Number: \_\_\_\_\_

**Section B – Information for Use/Disclosure** (NOTE: An additional form must be used to authorize the use/disclosure of psychotherapy notes.)

Protected health information is information created, received, transmitted or stored by the Fund or Fund Entities which relates to your past, present, or future physical or mental health, health care, or payment for health care, and either identifies you or provides a reasonable basis for identifying you.

**Check all that apply for the information to be used or disclosed:**

Any and all protected health information, including eligibility, benefits and benefit payments.  
Protected health information about treatment for the following condition or injury:

\_\_\_\_\_

Protected health information about treatment for the following provider of service:

\_\_\_\_\_

**Check here if your authorization includes the disclosure of information regarding:**

AIDS, ARC or HIV testing/treatment  
Substance abuse (including alcoholism). The recipient of this information must obtain an additional authorization from me before they may re-disclose the information.  
Mental Health Services (excluding psychotherapy notes)

**Section C – Authorized Uses / Disclosures**

**Disclosure by Fund or Fund Entities:**

I authorize the Fund or Fund Entities to disclose my protected health information described in Section B to the following persons and/or entities for their use: \_\_\_\_\_

I authorize the persons and / or entities listed above to use my protected health information described in Section B for the following purposes (or write "At My Request"): \_\_\_\_\_

**Disclosure to Fund or Fund Entities:**

I authorize the following persons and/or entities to disclose my protected health information described in Section B to the Fund or Fund Entities: \_\_\_\_\_

I authorize the Fund or Fund Entities to use my protected health information described in Section B for the following purposes:

\_\_\_\_\_

**Section D – Expiration and Revocation**

This authorization is valid from the date of my signature below and will expire: On \_\_\_\_/\_\_\_\_/\_\_\_\_; OR when the following occurs: \_\_\_\_\_

I may revoke this authorization at any time by sending a written request on a standard form available by contacting 833-767-0172. However, I understand that revocation will not affect actions taken by the Fund or Fund Entities prior to receiving my written request.

**Section E – Signature**

**SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

*If a personal representative signs this authorization on behalf of the individual, specify your relationship to the individual including your authority to sign.*

Personal Representative's Name: \_\_\_\_\_

Relationship to the individual and authority to sign: \_\_\_\_\_

*(Unless you are the parent of a minor child, please provide proof of your relationship to the individual)*

**WE WILL PROVIDE YOU A COPY OF THIS SIGNED AUTHORIZATION**

# INSTRUCTIONS FOR COMPLETING THE AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

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The Authorization is not valid unless it is filled out completely.

## Section A: Requesting an Authorization

- 1) Fill in the participant's or beneficiary's first and last name
- 2) Fill in the participant's full street address, including city, state and ZIP code
- 3) Fill in the participant's or beneficiary's Social Security number
- 4) Fill in the participant's or beneficiary's telephone number, including area code

## Section B: Information for Use/Disclosure

- 1) Review the definition of protected health information (PHI) and then check all boxes that apply regarding the information to be used or disclosed.
- 2) If applicable, Fund participants and beneficiaries must check the following additional boxes for disclosures that:
  - a. Include information related to AIDS, ARC or HIV testing/treatment
  - b. Include information related to substance abuse (including alcoholism)
  - c. Include information related to mental health services

## Section C: Authorized Uses/Disclosures

- 1) If the participant or beneficiary would like the Fund to disclose his/her protected health information (PHI), check "Disclosure by Fund or Fund Entities" and list to whom this information shall be disclosed and the purpose for the disclosure.
- 2) If the participant or beneficiary is requesting that others disclose their PHI to the Fund, check "Disclosure to Fund or Fund Entities" and list the person(s) who will disclose the information.

## Section D: Expiration and Revocation

- 1) Fill in the date for when the authorization expires (day, month and year) or if applicable, the event/activity that will trigger the expiration of the authorization.
- 2) If the participant or beneficiary would like to revoke the authorization, he/she may do so at any time. The request must be submitted in writing using the standard Fund Revocation Form. The participant or beneficiary may obtain a standard form by calling (844) 683-0683 or (517) 321-7502.

## Section E: Signature

- 1) The participant or beneficiary must sign and date the authorization. If the individual that signs the authorization form is a personal representative, the individual must specify the relationship to the participant or beneficiary.
- 2) The personal representative must print his/her name and detail relationship to participant or beneficiary and authority to sign. If the personal representative is someone other than the parent of a minor child, written proof must be provided.

The requesting individual must be provided a copy of the completed authorization form. The original authorization form should be saved for future review and action surrounding the authorization.

## Internal Use Only

This document needs to be retained and stored according to Fund procedures.