PLUMBERS' WELFARE FUND, LOCAL 130, U.A.
RETIREE MEDICAL PLAN OF THE PLUMBERS' WELFARE FUND, LOCAL 130, U.A.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION *FOR DEPENDENTS AGE 18 AND OVER*

I. Information About the Use or Disclosure of Protected Health Information ("PHI")

Participant/Patient: _____

I (name of Participant/Patient), _____, hereby authorize the use or disclosure of my written, electronic and oral PHI, as described in this authorization.

- I am authorizing the plan of benefits sponsored by the Plumbers' Welfare Fund, Local 130 UA and the Retiree Medical Plan of the Plumbers' Welfare Fund, Local 130, U.A., ("Plans") and its affiliates or Business Associates to provide my health information.
- Please specify the individual/organization authorized to receive your health information:
  ☐ Spouse ☐ Parent(s) ☐ Employer ☐ Attorney ☐ Other: _____

Name: _____Daytime Tele: (_____) _____-_____

Address: _____

II. **Description of Specific Information You Wish the Plans to Disclose:** (check all boxes that apply)

☐ All claims information for benefits covered under the Plans.
☐ Other (please be as specific as possible) _____
_____

III. Purpose of the Use or Disclosure – The purpose(s) for which the individual named in Part (I) of this Authorization Form may have access to my PHI is as follows: (mark all that apply):

☐ ***For any health-related purpose*** ☐ Payment for health care
☐ Health care claims only ☐ Coordination of benefits ☐ Health care claim status
☐ Premiums and copayments ☐ Other (explain):_____

IV. Effective Period of this Authorization – This authorization form is valid for the period designated below:

☐ ***The later of (i) the date that I cease to be covered by the Plans, or (ii) the date that I no longer have any outstanding claims for benefits under the Health Plan.***
☐ Give specific date or occurrence (Example: "When my auto accident case is settled."): _____
☐ Until I cancel it by submitting an applicable cancellation form from the Fund Office.
You may cancel this authorization at any time, no matter which option you select above, by submitting to the Fund Office a properly completed cancellation of authorization Form. This Authorization is valid for one year from the date I sign this form unless I cancel the form or specify another date or event above.

V. Important Information About Your Rights - I have read and understand the following statements about my rights:

- I understand that I have the right to revoke this authorization at any time by notifying the HIPAA Privacy Officer of the Plans in writing at ***Plumbers' Welfare Fund, Local 130 UA, 1340 W. Washington Blvd., Chicago, IL 60607***. I understand that the revocation is only effective after it is received and logged by the Plans. I understand that any use or disclosure made prior to the revocation under this authorization will not be affected by a revocation.
- I understand that after this information is disclosed, federal law might not protect it and the recipient might disclose it again.
- I understand that I am entitled to receive a copy of this authorization.

You may refuse to sign this authorization. The refusal will not affect your ability, according to the Plans' provisions, to obtain treatment, receive payment of benefits according to the Plans, or eligibility for benefits unless authorized by law.

VI. Signature*

_____ Date: _____
*If you are acting as the Personal Representative of the individual whose PHI is to be disclosed, you must provide proof of your authority to act for that individual.

Fund Office Use Only *Date Mailed: _____ Processed By: _____ _ Status: _____*