Plasterers & Cabinet Makers Welfare Fund

Authorization for Release of Protected Health Information (PHI) By the Welfare Fund

You MUST complete all of the information requested in this form for your authorization to be valid.

I authorize the Plan the use of disclosure of my Protected Health Information (PHI) as described in this authorization. I understand the Plan may not condition my treatment, payment, enrollment or eligibility for benefits on whether or not I give the authorization listed in this form.

(1) **The Plan can release PHI to:** The Plan, its agents or subcontractors ("Business Associates") is authorized to release the PHI described below to the following person, class of persons, or organization:

☐ My spouse ☐ My Union

☐ My parents ☐ My Employer

☐ Other (Print Name or Position): _____

(2) **The information that may be used or released is:**

☐ Medical information held by the Plan from the following doctor, clinic, or hospital:

_____

☐ Information held by the Plan concerning my eligibility, claims decisions and payments.

☐ Other. Please specify below.

_____

(3) **Right to revoke:** I understand that I have the right to revoke this authorization at any time by notifying the Plan's Contact Person in writing at the address listed at the top of this Form. I understand that the revocation is only effects after it is received and logged by the Plan. I understand that any use or disclosure made prior to the revocation under this authorization will not be affected by a revocation.

(4) **Re-Release of Information:** I understand that after this information is released, federal law might not protect it and the recipient might re-release it I also understand and agree to hold the Plan and any of its agents and subcontractors harmless if the information is re-released.

(5) **Copy:** I understand that the Plan will give me a copy of this authorization

(6) **THE AUTHORIZATION WILL EXPIRE ON THE DATE ON WHICH YOUR ELIGIBILITY UNDER THE PLAN TERMINATES UNLESS YOU SPECIFY ANOTHER DATE OR TERMINATION EVENT BELOW.**

☐ Other: _____

Your Signature:_____ Date: _____

Print Your Name: _____

If you are covered under the Plan as a Dependent, please print the name and social security number of the covered employee:

Name: _____ SSN: _____

Mail or Fax Completed Forms to the Fund Administrator:

3001 Metro Drive – Suite 500, Bloomington, MN 55425
Fax: 952-851-3521