:

Member's Name: _____

Social Security No:_____

LOCAL 103, I.B.E.W. HEALTH BENEFIT PLAN

AUTHORIZATION FOR THE DISCLOSURE OF PROTECTED HEALTH INFORMATION

STEP 1► If you want to allow your spouse, your parent or some other person or entity to have access to ***your protected health information*** maintained by the Local 103, I.B.E.W. Health Benefit Plan or its agents or business associates, state ***your*** name along with the following information:

Your Name: _____ **Social Security No.**:_____

Address: _____ **Phone:** _____

_____

STEP 2► ***To Whom*** do you want to authorize the Local 103, I.B.E.W. Health Benefit Plan or its agents or business associates to disclose your health information (fill in the following):

Name of Person or Entity: _____ **Social Security No.**:_____

Tax ID No. (if entity): _____

Address: _____

Phone: _____

_____

STEP 3► ***What health information*** do you want to authorize be disclosed to the person or entity you identified above under Step 2 (check one only):

☐ All of my protected health information

☐ Only the following (please be specific): _____

_____

STEP 4► Do you want to describe the purpose for which you are authorizing the disclosure? (check one only):

☐ No. Provide access or disclosure at the request of the individual identified in Step 2.

☐ Yes. (please describe the purpose): _____

_____

STEP 5► When do you want your authorization to expire? (choose one only):

☐ On the following date: ____/ ___/_____.
MM DD YR

☐ Upon the occurrence of the following event related to my health care or to the purpose(s) for which I have authorized the use and/or disclosure of my health information:_____

☐ On the earlier of the date I provide notice to the Plan in writing (I) of my divorce from my spouse (who is identified under Step 2) or (II) the death of such spouse.

☐ On the date I provide notice to the Plan in writing of the death of my parent (who is identified under Step 2).

STEP 6► Complete the following declaration and sign and date this form in the presence of a notary public.

Declaration

This Authorization form is completed by me voluntarily and of my free will. I understand that I am under no obligation to sign this form. The Plan may not condition payment, enrollment in the Plan or eligibility for health care benefits on my decision to sign this authorization***. I understand that once the Plan or its agents or business associates disclose my health information to the person or entity designated by me, such health information may no longer be subject to the privacy rules and protections of HIPAA and such person or entity may re-disclose my health information to others without obtaining my authorization. I understand that I have the right to revoke this authorization at any time.*** I also understand that my revocation of this authorization must be in writing. To obtain a copy of an authorization revocation form I may contact the Local 103, I.B.E.W. Health Benefit Plan, 256 Freeport Street, Boston, MA 02122 (617) 288-5999 and request that a revocation of authorization form be mailed to me. I am aware that my revocation will not be effective as to uses and/or disclosures of my health information that the Plan and/or the Plan's agents or business associates have already made in reliance upon this authorization. I understand that if the Plan initiates or seeks an authorization from me and I agree to sign this authorization, which I am not required to do, I must be provided with a signed copy of it.

I, _____ (please print your name), have had an opportunity to review and understand the contents of this form. By signing this form, I am confirming that it accurately reflects my wishes.

_____ _____/_____/_____

Your Signature Date

NOTARY'S ACKNOWLEDGMENT

State of _____

County of _____

On the _____ day of _____, 20___, before me came _____, to me known
(Your Name)

to be the person described herein and who executed the foregoing Declaration and he/she duly acknowledged to me that he/she executed the same as his/her free act and deed for the purposes therein contained.

_____

Notary Public

My commission expires: _____