SHEET METAL WORKERS' LOCAL 36

MEMBER'S
PROTECTED HEALTH INFORMATION (PHI)
AUTHORIZATION FORM

Member's Name:_____ **SSN**:_____

I authorize the disclosure of PHI related to (choose one):

☐ All claims and other documents related to my health care – this includes information made available online.

☐ Specific claim(s) data – Please provide Date of Service and Provider Name or other information specifically identifying the claim(s)_____

☐ Other:_____

Entity Authorized to Disclose PHI:
Sheet Metal Workers' Local 36 Welfare Plan
2319 Chouteau Avenue, Ste. 300
St. Louis, MO 63103
Phone: 314-652-8175 Fax: 314-652-9356

Person(s) Authorized to Receive PHI:

***Dependents over 18: to view your PHI online, you must be listed on the main members PHI form, and they must be listed on yours.**

Name_____ Relationship_____ Phone#_____

Name_____ Relationship_____ Phone#_____

Name_____ Relationship_____ Phone#_____

Name_____ Relationship_____ Phone#_____

This disclosure of PHI is made at the request of the individual unless otherwise noted here:_____

Expiration Details (choose one):

☐ This authorization is valid for the duration of the individual's eligibility with the Fund
☐ This authorization expires on ___/___/_____
☐ This authorization expires in the event of (please describe an applicable expiration event):_____

1. I understand that I may revoke this authorization at any time by notifying the Fund in writing. Details on the conditions of revocation may be found in the Fund's Notice of Privacy Practices, which is available upon request. In the case of revocation, I understand that changes will not be considered applicable to any actions taken before receipt of revocation.
2. I understand that payment for my healthcare benefits will not be affected if I do not sign this form unless the Fund specifically requires this authorization to determine eligibility or enrollment information, or requires this document for use in underwriting or risk determination.
3. I understand that I may request to review the information described on this form, and that I may request a copy of this form after I sign it.

INITIALS:_____

I, the undersigned, have read the above information and hereby authorize the use or disclosure of my individually identifiable health information for the purpose described about. I understand this authorization is voluntary. I understand if the person/entity authorized to receive the information is not bound by HIPAA, the released information may no longer be protected by federal privacy regulations. Furthermore, I release Sheet Metal Workers' Local 36 Welfare Fund from any liability for any release made as a result of this authorization. (Form must be fully completed before signing)

_____

Signature of Individual or Representative **Date**

(For personal representatives, please attach a copy of documentation detailing legal responsibility.)