Laborers Health and Welfare Trust Fund for Northern California
220 Campus Lane, Fairfield, CA 94534-1498 • Telephone: (707) 864-2800 • Toll Free: 1-(800) 244-4530

(3Z)

Authorization For Use or Disclosure of Protected Health Information (PHI)

Section A: Must be completed for all authorizations

I hereby authorize the use or disclosure of my Protected Health Information described below. I understand that this authorization is voluntary. I understand that the released information will no longer be protected by federal privacy regulations.

Participant Name: _____ **S.S. Number:** _____

Persons/organizations providing the information:

_____

_____

Persons/organizations receiving the information:

_____

_____

Check-off the applicable box(es) below for the type of information you authorize the Laborers Health and Welfare Trust Fund for Northern California, Health & Welfare Plans to disclose:

☐ All information about participant and family members including status of claims, eligibility and coverage information.
☐ Participant Information Only ☐ Dependent Information Only ☐ Claims Status Only ☐ Coverage Information Only
☐ Other (please specify) _____

_____

Section B: Must be completed only if the Laborers Health and Welfare Trust Fund for Northern California, Health & Welfare Plans or its Business Associate has requested the authorization:

1. The Laborers Health and Welfare Trust Fund for Northern California, Health & Welfare Plans must complete the following:
   a. What is the purpose of the use or disclosure?

      _____

   b. Will the organization requesting the authorization receive financial or in-kind compensation in exchange for using or disclosing the health information described above? Yes ☐ No ☐

2. The participant or the participant's representative must read and initial the following statements:
   a. I understand that my health care and the payment for my health care will not be affected if I do not sign this form. Initials: _____
   b. I understand that I may see and copy the information described on this form if I ask for it, and that I get a copy of this form after I sign it. Initials: _____

Section C: Must be completed for all authorizations:

The participant or the participant's representative MUST READ, COMPLETE AND INITIAL the following statements:

1. I understand that this authorization will start on (indicate dates) _____/_____/_____ and expire on _____/_____/_____ . Note: If you do not indicate the dates above, we will use the signed date below as start date and not revoke this authorization until you notify us in writing. Initials: _____

2. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, but if I do it will not have any affect on any actions they taken before the organization received the revocation. Initials: _____

_____ _____

Signature of participant Date

(Form documenting representative status must be completed before signing.)

_____

Printed name of participant

• **YOU MAY REFUSE TO SIGN THIS AUTHORIZATION** •