SOUTHERN CALIFORNIA PIPE TRADES HEALTH & WELFARE FUND

HWM-F023

501 Shatto Place, 5th Floor ▪ Los Angeles, CA 90020 ▪ (800) 595-PIPE (CA only) ▪ (213) 385-6161 ▪ Fax: (213) 383-0725

AUTHORIZATION FORM

PURPOSE OF FORM

In order for the Southern California Pipe Trades Health & Welfare ("Fund") to use or disclose your Protected Health Information to someone other than you, you must complete this Authorization Form and return it to the Fund.

Protected Health Information ("PHI") is information that is created, received, transmitted or stored by the Fund which relates to your past, present, or future physical or mental health, health care, or payment for health care, and either identifies you or provides a reasonable basis for identifying you. Except as permitted by law, the Fund may not use or disclose PHI to persons other than those you specify on this form.

The Fund may request that you complete this form where the use or disclosure of information is necessary to carry out functions of the Fund. In addition, you may submit this form to the Fund because you want someone to request or receive your PHI from the Fund. This form is not needed if you are requesting your own PHI from the Fund.

PATIENT INFORMATION

NAME: _____

STREET: _____

CITY: _____

ZIP & STATE: _____

SSN: _____-_____-_____

Are you a dependent? ☐ **YES** ☐ **NO**

If **YES**, please state:

Relationship to member: _____

Member's Name: _____

Member's SSN: _____

PART I: Authorized Person

I authorize the Fund to disclose my protected health information (PHI) identified in Part II of this form to the following person. (Please designate no more then one person and will in their name and address)

FIRST **Middle Initial** **LAST**

STREET **CITY** **STATE** **ZIP**

RELATIONSHIP: ☐ **SPOUSE** ☐ **FAMILY** ☐ **OTHER:** _____

PART II: Authorization Period (maximum of ONE YEAR)

All Authorization Forms are valid for a maximum of one year from the effective date. You can also designate a specific authorization period of less then a year in the space provided. If effective date is provided, this Authorization Form shall remain valid for one year from the date received by the Fund Office.

Please authorize:

☐ **For the whole year, as long as I am eligible for benefits under the Plan**

☐ **Until** _____
(Please specify date or event)

EFFECTIVE DATE:

_____

(You may also void this Authorization Form at any time, no matter which option you select above, by submitting a properly completed Cancellation of Authorization Form to the Fund Office.)

PART III: Description of Information

I authorize the Fund to disclose my protected health information (PHI) – including written, electronic, or oral information, to the person(s) identified in Part I of this form in connection with the following information:

☐ **ALL claims information for benefits covered under the Plan for the period authorized in Part I**

☐ **SPECIFIC claims information (Mark all that apply)**

- ☐ **ALL MEDICAL claims**
- ☐ **ALL DENTAL claims**
- ☐ **ALL VISION claims**
- ☐ **ALL MENTAL claims**
- ☐ **ALL PRESCRIPTION claims**
- ☐ **OTHERS:** _____
- ☐ **Claims by SPECIFIC PROVIDER**
  Provider Name : _____
  Date of Services : _____

(Please be specific as possible)

(If you want different people to have access to different information, you will have to fill out separate forms for each individual)

PART IV: Purpose of use or disclosure

The purpose for which the individual named in Part I of this Authorization Form may have access to my PHI is as follows:
(Please mark all that apply)

- ☐ **For any purpose**
- ☐ **Health care claims or appeals**
- ☐ **Payment for health care**
- ☐ **Coordination of benefits**
- ☐ **Health care claim status**
- ☐ **Coverage**
- ☐ **Eligibility in Fund**
- ☐ **Premiums and co-payments**
- ☐ **Preauthorization**
- ☐ **Subrogation and Reimbursement**
- ☐ **Other purpose (explain):** _____

PART V: Acknowledgement and SIGNATURE

I understand that :

- **The Fund will provide a copy of this signed Authorization to me**
- **I have the right to refuse to sign this Authorization form**
- **I have the right to revoke this form at any time by submitting a Cancellation of Authorization Form to the Fund**
- **Cancellation will take effect as of the cancellation date or event, or once the fund receives a Cancellation of Authorization Form**
- **The person I am authorizing to receive my PHI may not be required to treat this information as confidential**

_____ _____

Your Signature
(or Signature of Personal Representative*)

Print Name

**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.*