HIPAA AUTHORIZATION FOR RELEASE
OF PROTECTED HEALTH INFORMATION

Section 1. I authorize **Fox Valley Laborers Health and Welfare Fund** to release:

Check all that apply:

_____ Claims Status
_____ Eligibility
_____ Eligibility Cards
_____ Hours Worked

Policy ID Number or Social Security Number: ____________________________

Policy Holder's Name: ____

This information may be released to the following:

____ ____________________

(Name) (Relationship) (Date of Birth)

Information will be used/disclosed for the following dependents:

____

Section 2 Drug and/or Alcohol Abuse, and/or Psychiatric, and/or HIV/AIDS Records Release

If my records contain information about drug and/or alcohol abuse, mental health, sexually transmitted diseases and/or other sensitive information, I agree to its release:

Drugs: Yes No HIV/AIDS: Yes No
Alcohol: Yes No Mental Health: Yes No
Sexually Transmitted Disease: Yes No

Section 3 Time Limit / Right to Revoke

If I want to cancel this authorization, I must submit a written notice to the Privacy Officer at Fox Valley Health and Welfare Fund. It is understood that information released prior to my written cancellation was made at my request and with my consent.

Section 4 Re-disclosure

I understand that the information disclosed by this authorization could be re-disclosed by the person receiving it and is no longer protected by federal or state legal privacy requirements.

Section 5 Signature of Individual or Personal Representative Who May Request Disclosure

I understand that I do not have to sign this authorization, that my treatment or payment for services will not be denied if I do not sign this Authorization, and that I can inspect or copy the Protected Health Information to be used or disclosed.

I hereby authorize Fox Valley Laborers Health and Welfare Fund to release the Protected Health Information as specified above.

____ ____________________

Signature of the Insured Date

____

Print Name of the Insured

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