Associated Administrators, LLC
UFCW Local 1500 Welfare Fund
P. O. Box 1095
Sparks, Maryland 21152-1095
Phone: (855) 266-1500
www.associated-admin.com

AUTHORIZATION
FOR RELEASE OF PROTECTED HEALTH INFORMATION

I, _____, hereby authorize the UFCW Local 1500 Welfare Fund to disclose my health information as described in this authorization.

(1) *Identify specific person/organization (for example: Jane Doe, or UFCW Local 1500) or class of persons (for example: "all physicians"), to whom the Fund is authorized to disclose the information.*

_____

_____

(2) *Describe the information to be disclosed by the Fund*:

_____

_____

(3) *Purpose of Authorization:* I am requesting that my information be disclosed for the following purpose (or, if you do not wish to state a purpose, please state "at the request of the individual"):

_____

_____

(4) *Expiration of Authorization.* This authorization will expire: ***[choose and complete one]:***
On the date my coverage under the Fund terminates.

Other specific date: _____
Upon the occurrence of the following event: _____.
I understand that the expiration date or event must be related to me or related to the purpose of the use or disclosure (for example: "when my claim is resolved").

(5) *Right to Revoke:* I understand that I have the right to revoke this authorization at any time by notifying Associated Administrators, LLC in writing at: Privacy Official, Associated Administrators, LLC, UFCW Local 1500 Welfare Fund, P.O. Box 1095, Sparks, MD 21152. I understand that the revocation is only effective after it is received by Associated Administrators, LLC. I understand that any use or disclosure made prior to the revocation of this authorization will not be affected by the revocation.

(6) *Potential for Re-disclosure:* I understand that after the information described in (2) above is disclosed pursuant to this Authorization, federal law might not protect it, and the recipient might re-disclose it.

(7) *Right to Copy:* I understand that I am entitled to receive a copy of this authorization.

(8) *Voluntary:* I understand that I am under no obligation to sign this form. I acknowledge that I am voluntarily signing this form to release my health information to the party I have designated.

(9) *Benefits Not Conditioned on Form:* I understand that the Fund may not condition treatment, payment, enrollment or eligibility for benefits on receipt of this authorization form.

I 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.

_____ _____

Date Individual's Signature

_____

Individual's Social Security Number

Individual's Address and Phone Number

_____

_____

_____

Personal Representative Section

If a Personal Representative executes the form on behalf of the individual, the Personal Representative warrants that he or she has the authority to sign this form on the basis of:

A power of attorney for health care purposes, notarized by a notary public (copy attached).

A court order appointing the person as the Individual's conservator or guardian copy attached).

An un-emancipated minor child's parent.

Other:_____

NOTE: This authorization will not be effective unless you provide all of the information requested.