Associated Administrators, LLC
UFCW Local 1500 Welfare Fund
P. O. Box 1095
Sparks, Maryland 21152-1095
Phone: (855) 266-1500
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HIPAA AUTHORIZATION FORM
FOR RELEASE OF PROTECTED HEALTH INFORMATION

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

_____ _____

Your Name *(Name of Person Giving Authorization)* **Relationship to Plan Participant** *(Self/Spouse/Child)*

_____ _____

If you are a Dependent, state **Plan Participant's Name** **Last 4 digits of Plan Participant's SSN**

I hereby authorize the UFCW Local 1500 Welfare Fund to disclose my health information as described below:

(1) I authorize the Fund to disclose information to the following person(s), organization(s) or entity: *(Examples: "My wife Jane Doe" / Attorney Name or Law Firm / Physician Name or Physician's Office)*

_____

_____

Address & Phone Number of Authorized Person/Entity: _____

_____

(2) I authorize the Fund to disclose the following information: *(If you wish to have no limits on what information can be disclosed, you may write "All HIPAA-protected information.")*

_____

_____

(3) Limitations on disclosure: If there are any limitations on what may be discussed, or when it may be discussed, please specify. *(Leave blank if there are no limitations)*

_____

_____

(4) Purpose of Authorization: I am requesting that my information be disclosed for the following purpose *(If you do not wish to state a particular purpose, you may write "At my request"):*

_____

_____

(5) Start Date of Authorization:

- ☐ Immediately, upon receipt/verification of this form
- ☐ Upon my mental incapacity or total disability as deemed by an appropriate court.
- ☐ Other specific date: _____
- ☐ Upon the occurrence of the following event: _____
- ☐ Upon my death (for release of information post-death regarding a prior coverage period.)

(6) Expiration of Authorization. This authorization will be valid until: ***[choose and complete one]***

- ☐ Indefinitely, as applicable to any period of coverage under the Fund, until my death.
- ☐ Indefinitely, as applicable to any period of coverage under the Fund, continuing after my death.
- ☐ Other specific date: _____
- ☐ Upon occurrence of the following event *(example: "Upon settlement of disputed claim"):*

_____

I understand that the expiration date or event must be related to me or related to the purpose of the use or disclosure.

(7) Right to Revoke: I understand that I have the right to revoke this authorization at any time by notifying the Fund in writing at: Fund Office, Privacy Officer, 911 Ridgebrook Road, Sparks, MD 21152. I understand that the revocation is only effective after it is received by the Fund and any use or disclosure made prior to the revocation of this authorization will not be affected by the revocation.

(8) 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.

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

(10) 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.

(11) 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.

_____	_____
Your Signature	Your Address
_____	_____
Date	City/State/Zip
_____	_____
Last 4 digits of your SSN	Your Phone Number

Personal Representative Attestation

(Required only if the above form is completed by anyone other than the authorizing individual)

If you are completing this form on behalf of the Authorizing Individual as a Personal Representative or other person with the legal authority to execute this HIPAA authorization, you warrant that you have the authority on the basis of:

- ☐ A power of attorney for health care or other legal authority
  (Attach copy of POA or legal document, required.)

- ☐ A court order appointing you as the individual's conservator or guardian
  (Attach court order, required.)

- ☐ An un-emancipated minor child's parent.

- ☐ A Personal Representative or Executor on behalf of a deceased individual.
  (Attach Letters of Representation or other legal document, required.)

- ☐ Other:_____

Note: The HIPAA Authorization will not be effective until the Fund has verified the basis selected above.

_____	_____
Name of Individual Completing Form	Your Address
_____	_____
Signature	City/State/Zip
_____	_____
Date	Your Phone Number (Required)