

**UNITE HERE Local 25 and Hotel Association Of Washington, D.C.  
Health and Welfare Fund**

911 Ridgebrook Road  
Sparks, Maryland 21152-9451  
Telephone: (410) 683-6500  
(800) 638-2972  
[www.associated-admin.com](http://www.associated-admin.com)

8400 Corporate Drive, Suite 430  
Landover, Maryland 20785-2361  
Telephone: (301) 459-3020  
(800) 638-2972  
[www.associated-admin.com](http://www.associated-admin.com)

**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 UNITE HERE Local 25 and Hotel Association of Washington, D.C. Health and 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)