Lithographers & Photoengravers
Local 285 Welfare Fund
911 Ridgebrook Road
Sparks, MD 21152-9451
Phone: (866) 559-6512
www.associated-admin.com

AUTHORIZATION
FOR RELEASE OF PROTECTED HEALTH INFORMATION

I, _____, hereby authorize the _____ Health and Welfare Fund to disclose my health information as described in this authorization (please fill in the name of your Health and Welfare Fund. If you are not sure, leave blank and be sure you have noted your Social Security Number on the next page -- the Fund office will fill in the Fund name for you).

(1) *Identify specific person/organization (for example: Jane Doe, or UFCW Local 400) 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 the Fund in writing at: Privacy Official, Fund Office, 911 Ridgebrook Road, Sparks, MD 21152. I understand that the revocation is only effective after it is received by the Fund. 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.