AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I authorize the use and disclosure of my Protected Health Information as described below.

My Protected Health Information is individually identifiable health information, including demographic information, collected from me or created or received by a health care provider, a health plan, my employer, or a health care clearinghouse and that relates to: (i) my past, present, or future physical or mental health or condition; (ii) the provision of health care to me; or (iii) the past, present, or future payment for the provision of health care to me.

The following individual, organization, or class of persons (e.g., group of individuals within the organization) is authorized to use or disclose my Protected Health Information:

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The following individual, organization, or class of persons is authorized to receive my Protected Health Information:

The Protected Health Information that may be used and disclosed is as follows:
[Describe in as much detail as possible the Protected Health Information that you wish to be used or disclosed. For example, the information to be used or disclosed may relate to payment, enrollment, or claims. If so, you should include, if available, the types of claims, dates of service, or types of service.]

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My Protected Health Information will be used or disclosed for the following purpose(s):
[Describe the reason for each use and disclosure of the Protected Health Information. If an individual initiates the authorization for his or her own purposes, insert "at the request of the individual."]

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I understand that if my Protected Health Information is to be received by individuals or organizations that are not health care providers, health care clearinghouses, or health plans covered by federal privacy regulations, my Protected Health Information described above may be re-disclosed and no longer protected by federal privacy regulations.

I understand that I may revoke this authorization at any time by sending a written notification to the Plan's Privacy Officer at the Fund Office, and this revocation will be effective for future uses and disclosures of Protected Health Information. However, I further understand that this

revocation will not be effective: (i) for information that the Plan already has used or disclosed, relying on this authorization or (ii) if the authorization was obtained as a condition for coverage in the Plan and, by law, the Plan has a right to contest the coverage.

This authorization expires [identify a specific date or event]:

_____

_____

Signature of Individual or Personal Representative: _____

Date: _____

Name of Individual or Personal Representative: _____

Description of Personal Representative's Authority: _____