# LABORER'S DISTRICT COUNCIL
# HEALTH & WELFARE TRUST FUND

**C/O CARDAY ASSOCIATES, INC.**
**7130 Columbia Gateway Drive Suite A**
**Columbia, MD 21046**
**(410) 872-9500 or (800) 386-3632**
**FAX (410) 872-1275**

## AUTHORIZATION FORM
**(For Use or Disclosure of Protected Health Information)**

**PURPOSE OF THIS FORM**

In order for the Laborer's District Council Health &Welfare Trust Fund to use or disclose your Protected Health Information to someone other than you, you must complete this Authorization Form and return it to the Fund.

Protected Health Information ("PHI") is information that is created, received, transmitted or stored by the Fund which relates to your past, present, or future physical or mental health, health care, or payment for health care, and either identifies you or provides a reasonable basis for identifying you. Except as permitted by law, the Fund may not use or disclose PHI to persons other than those you specify on this form.

The Fund may request that you complete this form where the use or disclosure of information is necessary to carry out functions of the Fund. In addition, you may submit this form to the Fund because you want someone to request or receive your PHI from the Fund. This form is not needed if you are requesting your own PHI from the Fund. The Fund has a separate form for that type of request.

_____ _____
Name of Member (Please Print) Social Security Number

_____ _____
Name of Individual Requesting PHI (Please Print) Social Security Number

**PART I: Authorized Person(s)**

I authorize the Fund to disclose my protected health information (PHI) identified in Part II of this form to the following person: (please designate no more than one person and fill in his/her name and address)

☐ Spouse (Name/Address) _____
☐ Union Representative _____
☐ Attorney (Name/Address) _____
☐ Other Person (Name/Address) _____

**PART II: Description of the information to be used or disclosed**

I authorize the Fund to disclose my protected health information (PHI) (including written, electronic, or oral information) to the person identified in PART I of this form in connection with (mark all that apply): (If you want different people to have access to different information, you must fill out separate forms.)

☐ All claims information for benefits covered under the Plan (*optional*: from _____ to _____)
☐ Specific Medical, Dental, Vision, or Other Claim for Health Benefits
Provider: _____
Date(s) of Service: _____
☐ All Medical Claims (*optional):* from _____ to _____)

☐ All Dental Claims (*optional):* from _____ to _____)

☐ All Vision Claims (*optional):* from _____ to _____)

☐ All Mental Health Claims (*optional):* from _____ to _____)

☐ Other (please be as specific as possible) _____

**PART III: Purpose of use or disclosure**

The purpose(s) for which the individual(s) named in Part I of this Authorization Form may have access to my PHI is as follows: (mark all that apply):

☐ Health care claims or appeals ☐ Payment for health care

☐ Coordination of benefits ☐ Health care claim status ☐ Coverage

☐ Eligibility in the Fund ☐ Premiums and copayments ☐ Preauthorization

☐ Subrogation and reimbursement ☐ Other purpose (explain): _____

☐ I do not wish to state the purpose of the use or disclosure of PHI.

**PART IV: Effective Period of the Form**

- This Authorization Form is valid for the period designated below:

  ☐ For as long as I am eligible for benefits under the Plan;

  ☐ Only until the information requested on this Form is provided to the individual identified on this form.

  ☐ Until _____(please provide a date or event);

  ☐ Until I cancel it by submitting a Cancellation of Authorization Form.

  You may also cancel this authorization at any time, no matter which option you select above, by submitting to the Fund Office a properly completed Cancellation of Authorization Form.

**PART V: Acknowledgment and Signature**

I understand that:

- **THE FUND WILL PROVIDE A COPY OF THIS SIGNED AUTHORIZATION TO ME.**
- **I HAVE THE RIGHT TO REFUSE TO SIGN THIS AUTHORIZATION FORM.**
- **I HAVE THE RIGHT TO REVOKE THIS FORM AT ANY TIME BY SUBMITTING A CANCELLATION OF AUTHORIZATION FORM TO THE FUND.**
- **CANCELLATION WILL TAKE EFFECT AS OF THE CANCELLATION DATE OR EVENT, OR ONCE THE FUND RECEIVES THE CANCELLATION OF AUTHORIZATION FORM.**
- **THE PERSON I AM AUTHORIZING TO RECEIVE MY PHI MAY NOT BE REQUIRED TO TREAT THIS INFORMATION AS CONFIDENTIAL.**

_____ _____

Your Signature (or Signature of Personal Representative*) Date

*If you are acting as the Personal Representative of the individual whose PHI is to be disclosed, you must provide proof of your authority to act for that individual.