**PRESSMEN WELFARE FUND**
**7130 Columbia Gateway Dr., Suite A**
**Columbia, MD 21046**
**(410) 872-9500**

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

## PURPOSE OF THIS FORM

In order for the ENTER FUND NAME HERE to use or disclose 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 Individual (Please Print) Social Security Number

**PART I: Authorized Person(s)**
I authorize the Fund to disclose the PHI identified in Part II of this form to the following person(s): (please designate no more than one person(s) and fill in their name and address)

☐ Spouse____________________________________________________________

☐ Attorney___________________________________________________________

☐ Other Person(s) _____________________________________________________

**PART II: Description of the information to be used or disclosed**
I authorize the Fund to disclose PHI (including written, electronic, or oral information) to the person(s) 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.)

___Specific Medical, Dental, Vision, or Other Claim for Health Benefits
Provider: ______________________________
Date(s) of Service: ______________________
___All Medical Claims
___All Dental Claims
___All Vision Claims
___All Mental Health Claims
___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 for the Fund
___Premiums and copayments
___Preauthorization
___Subrogation and reimbursement
___Other event (please state what the event is): ________________________________________
___I am requesting disclosure of PHI for my own purposes.

**PART IV: Validity of Form**

- The Fund will provide a copy of this signed Authorization Form to me.
- This Authorization form is valid until the **earliest** of:

(1) ____________________________________________________________(please provide date or event);
(2) The date the Fund receives my Cancellation of Authorization Form; or
(3) One year from the date I sign this form.

**PART V: Acknowledgment and Signature**

I understand that:

- **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(S) 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.

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