TEAMSTERS LOCAL 639 – EMPLOYERS HEALTH AND PENSION TRUST FUNDS

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION TO A FAMILY MEMBER, UNION REPRESENTATIVE, OR OTHER PERSON

Explanation of this Form: The Health Insurance Portability and Accountability Act ("HIPAA") privacy regulations, which provide you with certain rights related to your protected health information ("PHI"), became effective on April 14, 2003. In general, these privacy regulations prohibit, among other things, the Teamsters Local 639 – Employers Health and Pension Funds (the "Funds") from disclosing your PHI without your permission. You may, however, authorize the Funds to disclose your PHI to a family member, union representative, or other person by completing the following Authorization. You may complete an Authorization allowing the designated individuals to have on-going access to your PHI or you may complete an Authorization each time that you want PHI disclosed to a designated individual. Please note, however, that you are not required to authorize the Funds to share your PHI with a family member, union representative, or anyone else.

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1. My name is ____________________ and my Social Security Number is ____________________. (If I am a dependent, the participant through whom I am covered by the Funds is ____________________ and his/her Social Security Number is ______________). I hereby authorize my PHI to be disclosed as described in this Authorization.

2. I authorize the Funds to release PHI related to my health claims and eligibility records to the individuals identified in Section 4. This information may be given orally or in writing and may include, but is not limited to, claims detail, claims status reports, payment records, Explanation of Benefits forms, and coordination of benefits information.

3. This PHI is to be used by the individuals identified in Section 4 for the purposes of assisting me with obtaining necessary medical care, filing health care claims on my behalf, checking on the status of health care claims, and working with the Funds to resolve any other issues that may arise with respect to the health benefits that are provided to me by the Funds.

4. I authorize my above-described PHI to be disclosed only to the following identified individuals: (*There is no limit to the number of individuals you can list in this section.*)

______________________________	______________________________
Name and SSN	Describe Relationship (*i.e., spouse, parent, union representative – **this is optional***)
______________________________	______________________________
Name and SSN	Describe Relationship (*i.e., spouse, parent, union representative – **this is optional***)

5. I also request that the following limitations be placed on the disclosure of my PHI to the individuals identified in Number 4: (*This Section should only be filled out if you wish to limit the disclosures of your PHI to the individuals identified in Section 4.*) ______________________________

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6. I understand that the Funds may not condition my treatment, payment, enrollment, or eligibility for benefits on whether I agree to sign this Authorization.

7. I understand that once my PHI is disclosed pursuant to this Authorization, the federal privacy protections will no longer apply to the disclosed PHI, and thus, the individuals described in Section 4 to whom my PHI is disclosed may re-disclose that PHI.

8. I understand that I have the right to revoke this Authorization at any time by sending a letter or revocation form:

Privacy Officer
Teamsters Local 639 – Employers Health and Pension Trusts
3130 Ames Place, NE
Washington, DC 20018-1593.

I understand that the revocation will take effect on the date that it is received by the Privacy Officer. However, I understand that any revocation will be effective only to the extent that the Funds has not already disclosed my PHI based on this Authorization.

9. This Authorization will expire at the end of my enrollment in the Funds or, if earlier, on the following date or event: *(e.g., One year from the date I signed the Authorization)* ____________________

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Printed Name (of person giving authorization)

_______________________________ _______________________
Signature of person giving authorization Date

____
Name of personal representative (if applicable)

_______________________________ _______________________
Signature of personal representative (if applicable) Date

____.
Description of personal representative's authority to act for the individual (if applicable)