# HIPAA* General Authorization for Disclosure of Protected Health Information (PHI)/Electronic Protected Health Information (ePHI)

***Health Insurance Portability and Accountability Act of 1996***

St. Louis – Kansas City Carpenters Regional Health Plan (Plan)
1419 Hampton Avenue, St. Louis, MO 63139
Phone: (314) 644-4802 | Toll-Free: (877) 232-3863 | Fax: (314) 678-1110 | Email: benefits@laborfunds.org

I, the **Covered Individual** listed below, hereby request and authorize the Plan to disclose my **protected health information** (PHI) to the **Authorized Party** designated below. This Authorization is provided in addition to, and not restrictive of, any other consent or authorization I have given, or may give, to the Plan concerning my health information. By providing my signature below, I authorize my PHI/ePHI to be used or disclosed by the Plan as described in this authorization.

## A. Covered Individual whose PHI is authorized to be disclosed – Please PRINT:

| Covered Individual Last Name | Covered Individual First Name | Cov Ind Middle Name |
|---|---|---|
| | | |

| Date of Birth | Last 4 Covered Individual SSN | Best Contact Phone Number |
|---|---|---|
| | | |

## B. Authorized Party* to receive Covered Individual's PHI upon request – Please PRINT:

**Covered Individual listed in Section A cannot be the Authorized Party in Section B*

**The Plan may disclose the following PHI/ePHI to the Person/Entity listed below (choose all that apply):**

☐ Entire Medical Record ☐ Mental/Behavioral Health Information, excludes Psychotherapy Notes

☐ Genetic Information ☐ Other, please list: _____

| Full Name of Person or Entity authorized to receive PHI/ePHI: | Relationship | Phone Number |
|---|---|---|
| | | |
| Full Name of Person or Entity authorized to receive PHI/ePHI: | Relationship | Phone Number |
| | | |

## C. This Authorization will Expire (check one):

☐ One year from the date coverage terminates ***OR*** ☐ Indicate a different Expiration Date: _____

## Important Information Concerning Covered Individual Rights

1. The Covered Individual is the participant or dependent covered under the St. Louis-Kansas City Carpenters Regional Health Plan.
2. The Covered Individual's signature on this form will not affect your treatment, payment, enrollment in health plan or eligibility for benefits.
3. Upon request, a copy of this signed Authorization will be sent to the Covered Individual listed in Section A.
4. The Covered Individual has the right to inspect or copy the protected health information to be disclosed under this Authorization.
5. Information used or disclosed under this Authorization may be subject to re-disclosure by the person or entity authorized by the Covered Individual and may no longer be protected by Federal Health Information Privacy Laws.
6. The Covered Individual may refuse to sign this Authorization.
7. If signed by a legally authorized Personal Representative (Power of Attorney, etc.), legal documentation must be attached.
8. The Covered Individual may revoke (cancel) this Authorization at any time in writing. A HIPAA Revocation Form is available from the benefit office and will be provided upon request. Please note: Any revocation of this Authorization will not apply to any action that the Plan may have already taken on the Covered Individual's behalf before receipt of the signed HIPAA Revocation Form.

## D. Covered Individual's Authorization to Release Information:

_____ _____

**Covered Individual Signature** **Date**

*(Signature of Parent if Covered Individual is a minor under the age of 18) or (Legal Personal Representative, see #7 above)*

_____ _____

**Legal Personal Representative's Name – please print** *(if applicable)* **Personal Representative's Phone Number**