Authorization for Release of Protected Health Information (PHI) / (ePHI)

Mid-America Carpenters Regional Council Health Fund (Fund)
St. Louis-Kansas City Region
1419 Hampton Avenue, St. Louis, MO 63139 *Attn: Privacy Officer*
Phone: (314) 644-4802, option 1 | Fax: (314) 678-1110 | Email: benefits@laborfunds.org

Reset form

Complete this form entirely – be sure to answer all questions. If you are submitting this form other than in person, for identification purposes, you **must** also submit a copy of a valid government-issued identification card. Acceptable forms of ID include a driver's license, state ID, passport, or resident alien identification card.

Complete electronically or print clearly using black or blue ink. This form requires you to print, sign, and return to our office.

Federal regulations require the Fund to follow procedures to protect the privacy of your health information within the control of the Fund known as Protected Health Information or PHI. PHI is individually identifiable information or records that the Fund has in any form (paper, electronic, oral) that relates to any one or more of the following: an individual's mental or physical health status or condition, provision of health care to an individual, or payment for the provision of health care to an individual. The Fund must obtain your authorization before releasing your PHI in those circumstances where the law or the Fund's privacy practices do not otherwise permit or require disclosure. Please use this form for this purpose - it is preferred over other authorizations for release of PHI.

SECTION 1: PARTICIPANT INFORMATION (check one): ☐ Active Participant ☐ Retired Participant	
Participant/Retiree Full name (Last, MI, First)	Last 4 Social Security Number (SSN) or UMR/UHC ID

SECTION 2: COVERED INDIVIDUAL (PARTICIPANT OR DEPENDENT) TO WHOM THE PHI RELATES	
Covered Individual Full Name (Last, MI, First)	Date of Birth (MM/DD/YYYY)
Phone Number	and/or Email Address*

* I authorize the Fund, its representatives, or its third-party service providers to contact me by telephone, cellular phone, e-mail, and/or at the mailing address I provide on this form, for purposes of Fund administration and healthcare related activities such as processing this authorization form. I consent and agree that the Fund and its third-party service providers may make calls or send text messages to me using prerecorded messages or artificial voice or through the use of an automatic telephone dialing system to any phone number provided on this form, including to my cellular phone, that could result in charges to me. I understand I may revoke my consent to receive such calls or messages sent to my cellular phone at any time.

SECTION 3: AUTHORIZATION	
I hereby authorize the disclosure, receipt, and use of my Protected Health Information (PHI) records as described in this Authorization.	
Person or entity being authorized to receive and use my PHI from the Fund:	
Person or Entity Name	Contact Person
Contact Phone Number	Mailing Address (Street, City, State, Zip)

What types of PHI may be used and disclosed by the Funds? (check only one)

☐ My complete health record maintained by the Fund Office, including, but not limited to, diagnoses, lab test results, treatment, and billing records for all conditions; or

☐ Other* (please specify): _____

* Examples may include records related to benefit eligibility or the lack of payment of benefits, or claims related to a certain injury.

SECTION 3: AUTHORIZATION (continued)

Specific purpose(s) of the use and disclosure of PHI under this Authorization
(e.g., disability benefit determination, workers' compensation claim, litigation, employment, insurance, etc.)

Duration of this Authorization (if no box is checked, this authorization will expire in one year from the signature date)

Unless revoked sooner, this Authorization will remain in effect (choose and complete only one):

☐ From _____ to _____ (MM/DD/YYYY)

☐ The date of the signature in Section 4 until the following event: _____
(for example: my death, termination of my enrollment in the Fund, etc.)

SECTION 4: SIGNATURE AND ACKNOWLEDGEMENT

I understand the following:

- I do not have to sign this Authorization. I am voluntarily signing this Authorization to permit the release of my Protected Health Information to the person(s) or entity(ies) listed above.
- I have the right to revoke this Authorization at any time by notifying the Fund Office in writing. Such revocation is only effective after it is received and recorded by the Fund Office. Any use or disclosure made prior to the revocation under this Authorization will not be affected by a revocation.
- After this Protected Health Information is disclosed, federal law might not protect it and the recipient might disclose it again.
- I am entitled to receive a copy of this Authorization.
- The Fund will not condition treatment, payment, enrollment, or eligibility for health plan benefits on receipt of an Authorization.
- A photocopy or facsimile of this signed Authorization will be considered as valid as the original signed copy.

The information I have provided on this Authorization is true and complete to the best of my knowledge and belief. I understand that making false statements or furnishing incomplete information may nullify this Authorization.

X _____ _____

Signature of Covered Individual or Personal Representative — Date

Personal Representative (if applicable) is:

☐ Parent ☐ Legal Guardian

☐ Personal Representative**

_____

Printed Name of Personal Representative* (if applicable)

** • *The Fund will automatically recognize any person who holds a legally valid Healthcare Power of Attorney for a covered individual as that covered individual's Personal Representative. If you have not already submitted a copy of the Healthcare Power of Attorney to the Fund Office, please include a copy with this form.*
• *A Power of Attorney will not be accepted unless it specifically addresses decisions related to healthcare.*

Mail, fax, or email this completed form to the address on page 1 of this form, Attn: Privacy Officer.