I.B.E.W. 292 HEALTH CARE PLAN

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION BY THE HEALTH PLAN

You MUST complete all the information in this Form for your Authorization to be Valid.

MAIL OR FAX THE COMPLETED FORM TO THE PLAN ADMINISTRATOR
6900 Wedgwood Road N., Suite 425, Maple Grove, MN 55311, Ph. (763) 493-8830 or Fax (763) 416-6196

I authorize the Plan to use or disclosure of my health Protected Health Information ("PHI") as described in this authorization.

(1) **The Plan can release PHI to**: The Plan, its agents or subcontractors ("Business Associates") is authorized to release the PHI described below to the following person, class of persons, or organization:

- ❑ My spouse [Name] _____
- ❑ My parents [Names] _____
- ❑ Other [Print Name or Position] _____
- ❑ My Employer
- ❑ My Union's Staff

Note: If you want to authorize the Plan to release information only to a specific person working for your employer or Union, check "Other" and print that person's name.

(2) **The information that may be used or released is**:

- ❑ Any and all:
- ❑ Medical information held by the Plan from the following doctor, clinic, or hospital:

  _____.
- ❑ Information held by the Plan concerning my eligibility, claims decisions and payments.
- ❑ Other. Please specify below:

  _____

  _____.

(3) **Right to revoke**: I understand that I have the right to revoke this authorization at any time by notifying the Plan's Contact Person in writing at the above address. I understand that the revocation is only effective after it is received and logged by the Plan. I understand that any use or disclosure made prior to the revocation under this authorization will not be affected by a revocation.

(4) **Re-Release of Information**: I understand that after this information is released, federal law might not protect it and the recipient might re-release it. I also understand and agree to hold the Plan and any of its agents and subcontractors harmless if the information is re-released.

(5) **THIS AUTHORIZATION WILL EXPIRE ONE YEAR FROM THE DATE ON WHICH YOU SIGN IT UNLESS YOU GIVE AN EARLIER DATE OR TERMINATION EVENT BELOW.**

- ❑ Other:_____.

Your Signature _____ **Date** _____

Print Your Name _____

Members Name _____ **I.D. # PIB XZ or SS#** _____

IF MORE AUTHORIZATIONS FOR ADDITIONAL FAMILY MEMBERS OVER THE AGE OF 18 ARE NEEDED PLEASE MAKE PHOTOCOPIES OF THIS FORM.