

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

This form is required in order for your personal information or claims information to be discussed with any other person or organization other than the patient. This form does not apply to physicians or hospitals. For example, if you wanted your spouse to check on the status of your claim, one of these signed forms would have to be on file at the claims office with your spouse listed under section "E" in order for your spouse to receive any information. The same would apply to any child who is age 14 and over, the parents must be listed. These rules were established under the government's HIPPA guidelines, (Health Insurance Portability and Accountability Act).

Please complete one form for each participant (member, spouse and each dependent over the age of 14), under the Alaska Pipe Trades UA Local 367 Health and Security Plan and return them to: Alaska Pipe Trades UA Local 367, C/O Administration Services Inc. PO Box 5434 Spokane WA 99205. If you need additional forms, or if you have any questions please contact the claims office or the Union Hall. Claims Office: ASI 1-800-716-0300, Union Hall: 1-907-562-2810. A copy of this form is acceptable.

I. Information about the Use or Disclosure of Protected Health Information:

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary and that I may revoke it any time by submitting my revocation in writing to Administration Services, Inc. at PO Box 5434, Spokane WA 99205.

- a.) Member's Name: _____
- b.) Member's ID/SS #: _____
- c.) Patient's Name: _____
- d.) Persons / Organizations authorized to provide the information:

Alaska Pipe Trades UA Local 367 Health and Security Trust Fund and;
Administration Services, Inc.

- e.) Persons / Organizations authorized to receive the information (for example, your spouse, a relative or your legal representative):

- f.) Description of information to be used or disclosed:
Health Care Claims (medical, dental, vision or weekly income)

- g.) This authorization will automatically expire one year from the date signed unless you designate a shorter time period: _____

II. Important Information about Your Rights

I have read and understand the following statements about my rights:

- ~ I may revoke this authorization at any time prior to its expiration date by notifying the providing organization in writing, but the revocation will not have any affect on any actins the organization took before I received the revocation.
- ~ I may see and copy the information described on this form if I ask for it.
- ~ I am not required to sign this form to receive my health care benefits (enrollment, treatment or payment).

Signature of Patient or Patient's Representative

Date

Please print name