PROTECTED HEALTH INFORMATION

AUTHORIZATION TO RELEASE INFORMATION

I.B.E.W. LOCAL 25 HEALTH & BENEFIT FUND

Gentlemen:

The Fund is hearby authorized to use or disclose Protected Health Information concerning myself, my spouse and dependent children under the age of 18, if applicable, (hereinafter collectively refurred to as the "Undersigned") in connection with Fund eligibility for benefits, enrollment, treatment, payment of medical expenses and administration of the Fund. The Fund Manager and/or the Health Fund Employees working in the claims department are authorized to make such use and disclosure.

The disclosure may be made to any provider of medical services to the Undersigned, to the Board of Trustees of the Fund, to any third party claims administrator retained by the Fund in connected with the payment of any claim and/or appeal concerning the health benefits of the Undersigned and to my spouse.

This Authorization expires as to the respective Undersigned individual when such individual is no longer a Participant in the Fund.

The Undersigned understands that this Authorization may be revoked by written notice to Paul F. Heinzel, the Fund's Privacy Officer.

The Undersigned understands that the information used or disclosed pursuant to this Authorization may be subject to redisclosure by the recipient, and may no longer be protected by federal or state privacy rules.

The Undersigned understands that the Fund will not condition enrollment in the Fund, eligibility for benefits or payment of benefits upon providing of this Authorization by the Undersigned.

The Undersigned have the right to inspect or copy the Protected Health Information used or disclosed pursuant to this Authorization upon submission of a written request to the Fund.

The Undersigned herby authorize the release of Protected Health Information.

Date: _____ _____

Participant's Signature

_____

Print Participant's Name

_____

Participant's S.S. Number

Date: _____ _____

Spouse's Signature

_____

Print Spouse's Name

_____

Spouse's S.S. Number