PROTECTED HEALTH INFORMATION

DEPENDENT CHILD OVER THE AGE OF 18

AUTHORIZATION TO RELEASE INFORMATION

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

Gentlemen:

The Fund is hereby authorized to use or disclose Protected Health Information concerning myself, (hereinafter referred to as the "Undersigned") in connected 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 connection with the payment of any claims and/or appeal concerning the health benefits of the Undersigned, and to my parents.

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

The Undersigned understands that this Authorization may be revoked by written notice to Rosa Arreaga-Negron, 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 the providing of this Authorization by the Undersigned.

The Undersigned has 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 hereby authorizes the release of Protected Health Information

Date: _____

_____

Dependent's Signature

_____

Dependent's Name

_____

Dependent's S.S. Number

_____

Dependent's Date of Birth