PROTECTED HEALTH INFORMATION
AUTHORIZATION TO RELEASE INFORMATION

IBEW Local 25 Health & Benefit Fund
372 Vanderbilt Motor Parkway
Hauppauge, NY 11788

Sir/Madam:

The Fund is hereby authorized to use or disclose Protected Health Information concerning myself in connection with the 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 me, 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 claim and/ or appeal concerning my health benefits, and to:

_____ _____
Name of Individual (*other than yourself*) Relationship

This Authorization expires when I am no longer a Participant in the Fund.

I understand that this Authorization may be revoked by written notice to Rosa Arreaga-Negron, the Fund's Privacy Officer.

I understand 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.

I the undersigned understand that the Fund will not condition enrollment in the Fund, eligibility for benefits or payment of benefits upon the providing of this Authorization.

I 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.

I hereby authorize the release of Protected Health Information as set forth above.

Date:_____

_____
Your Signature

_____
Your Name

_____
Your Social Security Number

_____
LU 25 Participants Social Security Number
(*If not one placing authorization*)