

PROTECTED HEALTH INFORMATION  
AUTHORIZATION TO RELEASE INFORMATION

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

Sir/Madam:

The Fund is hereby authorized to use or disclose Protected Health Information concerning myself, my spouse, and dependent children under the age of 18, if applicable, (hereinafter collectively referred 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 connection 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 understand that this authorization may be revoked by written notice to Rosa Arreaga-Negron, the Fund's Privacy Officer.

The Undersigned 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.

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 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 hereby authorize the release of Protected Health Information.

\_\_\_\_\_  
Participants Signature

\_\_\_\_\_  
Spouse's Signature

\_\_\_\_\_  
Participants Name

\_\_\_\_\_  
Spouse's Name

\_\_\_\_\_  
Last four digits of Participants Social Security No.

\_\_\_\_\_  
Last four digits of Spouse's Social Security No.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date

\_\_\_\_\_  
Notary Public Stamp

\_\_\_\_\_  
I.B.E.W. Local No. 25 H&B Fund Representative Signature

\_\_\_\_\_  
Notary Public Signature

*\*\* NOTE: If applicable, also complete Authorization Form to release information for Dependent Child Over the Age of 18 \*\**