BRICKLAYERS AND ALLIED CRAFTWORKERS, LOCAL 2, ALBANY, NEW YORK, HEALTH BENEFIT FUND
300 Centre Drive
Albany, New York 12203

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

IF YOU DO NOT FILL OUT THIS FORM COMPLETELY AND DO NOT PROVIDE ALL OF THE REQUESTED INFORMATION, WE WILL NOT HONOR YOUR AUTHORIZATION

Participant/Patient Name:_____ SS Number: _____
Participant/Patient Address:_____ Date of Birth: _____
_____

I hereby authorize the Bricklayers and Allied Craftworkers, Local 2, Albany, New York, Health Benefit Fund to disclose and discuss my individually identified health information (Protected Health Information or PHI) as described below. I understand that after the information is disclosed, it may no longer be protected by Federal Privacy Regulations and the recipient might re-disclose it.

Name and Address of
Persons/Organizations authorized to receive the information:
_____
_____
_____

If you would like the Fund to disclose and discuss the following information to the persons/organizations identified above, please initial or check the applicable items:

1. Enrollment or disenrollment information _____
2. Eligibility _____
3. Amount of contributions needed for coverage _____
4. Benefits available under Fund _____
5. Benefits received from Fund _____
6. Payment history, including coordination of benefits, subrogation and reimbursement issues _____
7. Your address, date of birth, marital status, dependant information and social security number _____
8. Status of claims, including appeals and payment disputes _____
9. Name and address of medical provider _____
10. Nature of treatment _____
11. Dates of service _____
12. Medical diagnosis/prognosis _____
13. Copies of all medical records concerning **any** physical or mental health conditions _____
14. Copies of medical records concerning **any** physical health condition _____
15. Copies of medical records concerning **any** mental health condition _____
16. There are no restrictions of on the type of information that may be disclosed and discussed with the person(s)/organization(s) designated above. _____

If you would like the Fund to only disclose copies of and discuss certain information, medical conditions or records, please identif that information, medical conditions and/or records:
_____
_____

Purpose of the request: (If you do not wish to state a purpose, please state, "At my request"):
_____
_____

This authorization will expire on _____. (Please provide specific date or specific event, such as loss of eligibility).

The participant/patient or the participant's/patient's representative must read and initial the following statement:

I understand that: this authorization is voluntary and that I have the right to refuse to sign this authorization; I am entitled to receive a copy of this authorization; I have the right to revoke this authorization at any time by notifying the Fund Office in writing; the revocation is only effective after it is received by the Fund Office and it will not effect any actions taken by the Fund Office based on the authorization and prior to receipt of the revocation; and the person/organization authorized to receive the information may not treat it as confidential and may re-disclose it.

Initials: _____

_____
Signature of participant/patient
(Form MUST be completed before signing.)

_____
Date:

Sworn to me before this day of
_____, 20____

_____
Notary Public

OR, if Signed by a Personal Representative of the Participant/Patient, the Personal Representative must Complete and Execute Below

Print name of participant's/patient's personal representative: _____

Relationship to the participant/patient: _____

Basis of authority to act for participant/patient (provide copy of any documentation establishing such authority):
_____

_____ _____
Signature of participant's/patient's personal representative: Date:
(Form MUST be completed before signing.)

Sworn to me before this _____ day of
_____, 20____

_____
Notary Public