IBEW Local 347 Electrical Workers Health and Welfare Fund

PO Box 26068
Salt Lake City, UT 84126-0068

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DESIGNATION OF AUTHORIZED REPRESENTATIVE AND PROTECTED HEALTH INFORMATION AUTHORIZATION FORM

Instructions:

This Designation of Authorized Representative and Protected Health Information Authorization Form ("Form") allows you to:

- Authorize the IBEW Local 347 Electrical Workers Health and Welfare Fund ("Plan") to disclose your Protected Health Information ("PHI") to another individual and/or entity; and
- Designate an individual to act as your authorized representative for purposes of the Plan's claims and appeals procedures.

If you wish to use this Form to authorize the Plan to disclose your PHI to another individual and/or entity, you must complete Sections A, B, C, D, F, G, and H below.

If you wish to use this Form to designate an individual to act as your authorized representative for purposes of the Plan's claims and appeals procedures, you must complete all of the Sections on this Form (i.e. you must complete Sections A, B, C, D, E, F, G, and H below).

Section A: Individual Authorizing Use or Disclosure

Covered Person's Name: Your name (if different):

Address:

Telephone Number: Individual ID Number:

E-mail Address: Social Security Number:

Section B: Authorized Use and / or Disclosure

I hereby authorize the Plan to use or disclose my PHI as described in this authorization. I understand that my PHI may include, but is not limited to, the following: medical records, emergency care records, billing statements, Explanation of Benefits, diagnostic imaging reports, transcribed hospital reports, laboratory reports, dental records, pathology reports, physical therapy records, hospital records (including nursing records and progress notes), claim status, claim information, confirmation or denial that treatment has occurred, treatment information, information on my physical or mental condition, and any personal or medical information related to the purpose of this authorization.

I further understand that my PHI may include information related to any of the following: genetic testing, mental health (excluding psychotherapy notes), HIV/AIDS, prescription medication, pregnancy, maternity, organ transplants, and chemical dependency (including alcohol and drug treatment). I authorize the use and/or disclosure of my PHI as indicated below.

Section C: Persons and Organizations Authorized to Use or Disclose my PHI

The following organization is authorized to **DISCLOSE** my PHI: **IBEW Local 347 Electrical Workers Health and Welfare Fund**

Section D: Persons and Organizations Authorized to receive my PHI

The following individuals and/or organizations are authorized to **RECEIVE** my PHI **(you MUST include your relationship to the recipient and the recipient's address and telephone number)**:

Representative Authorized to Receive PHI :

Name: _____ **Phone Number**: **( )** _____

Address: _____

Relationship to You: _____

Provide a Password: _____

I understand that I have the right to limit the information that the Plan releases under this authorization. For example, I may limit my Authorized Representative's access to information about a particular health care provider or a particular diagnosis/disease. Any such limitations must be described below in writing. I understand that by leaving this section blank, I am authorizing the Plan to use or disclose all of my PHI within the scope of its authority as set forth in Section B above.

Limitations on Disclosure _____

Representative Authorized to Receive PHI:

Name: _____ **Phone Number**: **( )** _____

Address: _____

Relationship to You: _____

Provide a Password: _____

I understand that I have the right to limit the information that the Plan releases under this authorization. For example, I may limit my Authorized Representative's access to information about a particular health care provider or a particular diagnosis/disease. Any such limitations must be described below in writing. I understand that by leaving this section blank, I am authorizing the Plan to use or disclose all of my PHI within the scope of its authority as set forth in Section B above.

Limitations on Disclosure: _____

I understand that this authorization to use or disclose my PHI will expire on the following date: _____
OR upon the occurrence of the following event (e.g., loss of Plan eligibility): _____
_____
_____ whichever comes first**.**

Section E: Designation of Authorized Representative for purposes of the Plan's Claims and Appeals Procedures:

I hereby appoint the individual(s) identified below to act as my authorized representative in connection with my claim(s) and appeal(s) for benefits under the IBEW Local 347 Electrical Workers Health and Welfare Fund. I authorize my representative to receive any and all information that is provided to me and to act for me in providing any information to the Plan that relates to claim(s) and appeal(s) for benefits under the Plan. All information and notifications from the Plan will be directed to the authorized representative appointed through this Form.

Authorized Representative #1:

Name: _____ **Phone Number**: **( )** _____

Address: _____

Relationship to You: _____ **Provide a Password:** _____

I understand that I have the right to limit the information that the Plan releases under this authorization. For example, I may limit my Authorized Representative's access to information about a particular health care provider or a particular diagnosis/disease. Any such limitations must be described below in writing. I understand that by leaving this section blank, I am authorizing the Plan to use or disclose all of my PHI within the scope of its authority as set forth in Section B above.

Limitations on Disclosure: _____

Authorized Representative #2:

Name: _____ **Phone Number**: **( )** _____

Address: _____

Relationship to You: _____ **Provide a Password:** _____

I understand that I have the right to limit the information that the Plan releases under this authorization. For example, I may limit my Authorized Representative's access to information about a particular health care provider or a particular diagnosis/disease. Any such limitations must be described below in writing. I understand that by leaving this section blank, I am authorizing the Plan to use or disclose all of my PHI within the scope of its authority as set forth in Section B above.

Limitations on Disclosure: _____

I understand that this appointment of my authorized representative and authorization to use or disclose my PHI to my authorized representative will expire on the following date:_____ OR upon the occurrence of the following event (e.g., resolution of my claim or appeal for benefits):_____

_____

_____ whichever comes first**.**

Section F: Term, Conditions and Revocation of this Authorization

I understand that this authorization does not provide the Authorized Representative designated in Section C or Section D with any authority, either implied or direct, over any treatment or direct care decisions. I understand that I may refuse to sign this Form and that the Plan may not condition payment for benefits, enrollment in the Plan, or eligibility for benefits on the execution of this Form.

I further understand that the information that is disclosed pursuant to this Form may be redisclosed by the recipient and, upon redisclosure, no longer be protected by those federal privacy laws.

I further understand that I have the right to revoke or end this authorization at any time. I understand that, if I do not want the person(s) named in Section C or Section D to remain my Authorized Representative, I must revoke this authorization **in writing** by giving notice of my decision to the Plan contact listed below. I understand that my revocation of this authorization will not affect any action taken by the Plan prior to the date that it received the revocation notice.

IBEW Local 347 Health and Welfare Plan
P.O. Box 26068
Salt Lake City, UT 84126-0068 Telephone: (844)347-IBEW (4239)

Section G: Purpose of Authorization

Purpose for which use or disclosure is authorized (NOTE: You are not required to provide a specific purpose; if left blank, the Plan will presume that the use or disclosure is simply being made at your request):

Section H: Signature / Authorization

I have had the opportunity to read and consider the content of this Form. I understand that, by signing this Form, I am authorizing the Plan to use and/or disclose my PHI to the person(s) and/or organization(s) listed in Section C and/or Section D of this Form for the purpose described above.

Signature: **Date:**

Please return the signed form to the Fund Office at the address listed at the top of this form.