



**AUTHORIZATION FOR RELEASE OF
PROTECTED HEALTH INFORMATION
NORTHERN CALIFORNIA TILE INDUSTRY
HEALTH & WELFARE TRUST FUND**

PATIENT'S DATA		INSURED'S DATA	
LAST NAME	FIRST NAME	LAST NAME	FIRST NAME
SOCIAL SECURITY NUMBER	DATE OF BIRTH	SOCIAL SECURITY NUMBER	DATE OF BIRTH
ADDRESS		ADDRESS	
TELEPHONE #	EMAIL ADDRESS	TELEPHONE #	EMAIL ADDRESS

I HEREBY AUTHORIZE THE USE AND/OR DISCLOSURE OF THE INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION AS DESCRIBED BELOW. I UNDERSTAND THAT THIS AUTHORIZATION IS VOLUNTARY. I ALSO UNDERSTAND THAT IF THE PERSON OR ORGANIZATION AUTHORIZED TO RECEIVE THE INFORMATION IS NOT A HEALTH PLAN OR HEALTH CARE PROVIDER, THE RELEASED INFORMATION MAY BE RE-DISCLOSED AND MAY NO LONGER BE PROTECTED BY FEDERAL PRIVACY REGULATIONS.

1. PERSON/ORGANIZATION (OR CLASS OF PERSONS) AUTHORIZED TO DISCLOSE PERSONAL HEALTH INFORMATION:

Health Fund and Plan Administrator

2. PERSON/ORGANIZATION (OR CLASS OF PERSONS) AUTHORIZED TO RECEIVE PROTECTED HEALTH INFORMATION (check as many as apply)

- | | |
|--|--|
| <input type="checkbox"/> Spouse (provide name) _____ | <input type="checkbox"/> Local 3 Business Manager/Agents |
| <input type="checkbox"/> Employer/HR Person: _____
(provide name) | <input type="checkbox"/> Other _____
(please specify) |

3. DESCRIPTION OF PROTECTED HEALTH INFORMATION THAT MAY BE USED/DISCLOSED:

- All Protected Health Information (PHI)
- Only the following PHI (please be specific):

4. PURPOSE OF USE/DISCLOSURE

- At the request of the authorized entity.
- Other (please specify)

5. THIS AUTHORIZATION IS EFFECTIVE UNTIL (check one):

- Revoked by Patient Specific Date: _____

6. I UNDERSTAND THAT I MAY REFUSE TO SIGN THIS AUTHORIZATION AND THAT MY REFUSAL TO SIGN WILL NOT AFFECT MY ABILITY TO ENROLL IN A HEALTH PLAN, OBTAIN HEALTH CARE TREATMENT OR PAYMENT OR ELIGIBILITY FOR BENEFITS. I FURTHER UNDERSTAND THAT I MAY ESTABLISH AN EXPIRATION DATE OR REVOKE THIS AUTHORIZATION AT ANY TIME BY PROVIDING WRITTEN NOTICE TO: PRIVACY OFFICER, NORTHERN CALIFORNIA TILE INDUSTRY HEALTH & WELFARE PLAN, C/O ALLIED ADMINISTRATORS, P.O. BOX 2500, SAN FRANCISCO, CA 94126.

7. MY REVOCATION WILL NOT AFFECT ANY ACTIONS ALREADY TAKEN IN RELIANCE ON THIS AUTHORIZATION, AND I MAY INSPECT OR COPY ANY INFORMATION TO BE USED OR DISCLOSED UNDER THIS AUTHORIZATION. A COPY OF THIS FORM, INCLUDING A FACSIMILE ORIGINAL SHALL BE TREATED AS AN ORIGINAL.

A COPY OF THIS FORM MUST BE GIVEN TO THE INDIVIDUAL.

Patient's Signature (or Signature of Legal Representative)

Date

Patient's Name (please print)

- FOR INTERNAL OFFICE USE ONLY -

- Copy Patient Copy LU 3 (if designated) Doc HBS