PLUMBERS & STEAMFITTERS MANAGED HEALTH CARE TRUST

AUTHORIZATION FOR RELEASE OF BENEFIT INFORMATION

I. Information about the Use or Disclosure of Protected Health and Benefit Information (PHI)

Participant, Retiree, or Surviving Spouse: _____ Social Security No. _____/_____/_____

I, (Patient's Name) _____, herby authorize the use or disclosure of my written, electronic and oral Protected Health Information (PHI), as described in this authorization.

1. Please check box to specify the individual/organization authorized to provide your health information:
   - ☐ U.A. Local 343 Pension Trust Funds (This applies, without restriction, only to benefits administered at the Trust Fund Office)
   - ☐ Specify if limiting authority

2. Please specify the individual/organization authorized to receive your health information (i.e. spouse and/or parent etc.):
   Name: _____ Relationship*: _____
   Name: _____ Relationship*: _____
   Name: _____ Relationship*: _____

***Any change in life circumstances that alters the relationship you have listed may invalidate this authorization.**

3. Please check the boxes to describe the information you wish the Trust Fund Office Staff to disclose, as appropriate within their Office:
   - ☐ All benefit issues
   - ☐ Other, please indicate specific circumstances: _____

4. State the purpose of this requested below (i.e. "To discuss benefits with the Trust Fund so I can better understand my Benefits" or if you do not wish to state a purpose, please state "At the request of (individual/organization listed in item 2 above)" _____

5. This authorization will expire on (give date or indefinitely): _____

II. Important Information About Your Rights – I have read and understand the following statements about my rights:

- I understand that I have the right to revoke this authorization at any time by notifying the Trust Fund in writing at 401 Nebraska Street, Vallejo CA 94590. I understand that the revocation is only effective after it is received and recorded by the Plan. I understand that any use or disclosure made prior to the revocation under this authorization will not be affected by a revocation.
- I understand that after this information is disclosed, federal law might not protect it and the recipient might disclose it again.
- I understand that I am entitled to receive a copy of this authorization.
- I understand the Plan will not condition treatment, payment, enrollment, or eligibility for benefits on receipt of an authorization.
- I understand that if I have authorized my spouse to receive information, this PHI access designation would be invalidated upon notification to the Trust Fund Office of a separation in any form of divorce.

You may refuse to sign this authorization. The refusal will not affect your ability, according to the Plan's provisions, to obtain treatment, receive payment of benefits or eligibility for benefits unless authorized by law.

III. Signature of Patient: _____ **Date:** _____

Please return this form to: **Paula Bailey-Trust Fund Administrator**
U.A. Local 343 Trust Funds
401 Nebraska Street
Vallejo CA 94590

Phone: **707*648*7066** **800*494*1048**
Fax: **707*648*2674**