

AFFILIATED TEAMSTERS HEALTH & WELFARE FUND
and
TEAMSTERS ALLIED PENSION FUND OF MARYLAND

9411 PHILADELPHIA ROAD, SUITE S • BALTIMORE, MARYLAND 21237

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AUTHORIZATION FORM
(For Use or Disclosure of Protected Health Information)

PURPOSE OF THIS FORM

In order for the Affiliated Teamsters Health and Welfare Fund ("Fund") to use or disclose your Protected Health Information to someone other than you, you must complete this Authorization Form and return it to the Fund.

Protected Health Information ("PHI") is information that is created, received, transmitted or stored by the Fund which relates to your past, present, or future physical or mental health, health care, or payment for health care, and either identifies you or provides a reasonable basis for identifying you. Except as permitted by law, the Fund may not use or disclose PHI to persons other than those you specify on this form.

The Fund may request that you complete this form where the use or disclosure of information is necessary to carry out functions of the Fund. In addition, you may submit this form to the Fund because you want someone to request or receive your PHI from the Fund. This form is not needed if you are requesting your own PHI from the Fund. The Fund has a separate form for that type of request.

**** THIS FORM MUST BE COMPLETED IN ITS ENTIRETY ****

PART I: Authorized Person (You must select one)

I authorize the Fund to disclose my PHI identified in Part II of this form to the following person:
(Please designate no more than one person and fill in their name and address)

Spouse Parent Union Representative Attorney Other Person

Authorized Person Name: _____

Authorized Person Address: _____

PART II: Purpose of use or disclosure (You must select at least one)

The purpose for which the individual named in Part I of this Authorization Form may have access to my PHI is as follows:
(Mark all that apply):

Health care claims or appeals Payment for health care Coordination of benefits Preauthorization
 Health care claim status Eligibility in the Fund Premiums and co-payments Coverage
 Subrogation and reimbursement

I am requesting disclosure of PHI for my own purposes.

Other purpose _____
(Explain)

PART III: Description of the information to be used or disclosed

I authorize the Fund to disclose my PHI; including written, electronic, or oral information to the person identified in Part I of this form for all claims information unless I select any of the options below. (Mark all that apply):

All Medical Claims for the following dates: From _____ to _____

All Dental Claims for the following dates: From _____ to _____

All Vision Claims for the following dates: From _____ to _____

All Mental Health Claims for the following dates: From _____ to _____

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Specific Medical, Dental, Vision, or Other Claim for Health Benefits

Provider: _____

Address: _____

Date(s) of Service: _____

Other _____

(Please be as specific as possible)

PART IV: Effective Period of the Form (You must select one)

This Authorization Form is valid for:

For as long as I am eligible for benefits under the Plan

Only until the information requested on this Form is provided to the individual identified on this form.

Until _____

(Please provide a date or event);

You may also cancel this authorization at any time, no matter which option you select above, by submitting to the Fund Office a properly completed Cancellation of Authorization Form or a written statement clearly indicating your desire to cancel the authorization(s) on file.

PART V: Acknowledgment and Signature

I understand that:

- **THE FUND WILL PROVIDE A COPY OF THIS SIGNED AUTHORIZATION TO ME UPON MY REQUEST.**
- **I HAVE THE RIGHT TO REFUSE TO SIGN THIS AUTHORIZATION FORM.**
- **I HAVE THE RIGHT TO REVOKE THIS FORM AT ANY TIME BY SUBMITTING A CANCELLATION OF AUTHORIZATION FORM TO THE FUND OR A WRITTEN STATEMENT CLEARLY INDICATING MY DESIRE TO CANCEL ANY AUTHORIZATIONS ON FILE.**
- **CANCELLATION WILL TAKE EFFECT AS OF THE CANCELLATION DATE OR EVENT, OR ONCE THE FUND RECEIVES THE CANCELLATION OF AUTHORIZATION FORM**
- **THE PERSON I AM AUTHORIZING TO RECEIVE MY PHI MAY NOT BE REQUIRED TO TREAT THIS INFORMATION AS CONFIDENTIAL.**

Member Name

Name of Individual (Please Print)

Member Social Security Number

Your Signature (or Signature of Personal Representative*)

Date

*If you are acting as the Personal Representative of the individual whose PHI is to be disclosed, you must provide proof of your authority to act for that individual