U.A. LOCAL 125 HEALTH AND WELFARE FUND

Authorization for the Release of Protected Health Information under HIPAA

Name	Date of Birth
Address	

I request, or my authorized representative requests, that health information regarding my care and treatment be released as set forth on this form.

1. In accordance with Iowa State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") 45 C.F.R. Parts 160 and 164, I authorize the U.A. Local No. 125 Health and Welfare Fund (the "Fund") to disclose the protected health information described below to [*individual or entity seeking the information*]

   _____.

2. This authorization for the release of protected health information is effective during the following time period (select one of the following options):

   a. ❑ from [*start date*] _____ to [*end date*] _____;

   OR

   b. ❑ from the date I sign this authorization until I properly revoke this authorization.

3. I authorize the release of (select one of the following options):

   a. ❑ Any or all of my health information in the Fund's possession or control;

   OR

   b. ❑ The following portion of my health information in the Fund's possession or control [*describe records to be released*]

   _____.

4. I understand that this protected health information may be used by the person whom I authorize to receive this information for medical treatment or consultation, billing, claims payment, or other purposes as I may direct.

5. I understand that I have the right to prospectively revoke this authorization at any time. However, no revocation is effective until it is delivered in writing with your signature (or that of your authorized representative) to the Fund.

6. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

7. I understand that information used or disclosed in accordance with this authorization may be disclosed by the recipient to others and may no longer be protected by state or federal law.

_____ _____

Signature *Date*

_____

Name

OR

_____ _____

Signature of Personal Representative *Date*

_____

Printed Name of Personal Representative

_____

Relationship to Patient