1199SEIU Funds
Benefit and Pension

AUTHORIZATION FORM For Release of Protected Health Information

- National Benefit Fund
- National Benefit Fund for Home Care Employees
- Licensed Practical Nurses Welfare Fund
- Greater New York Benefit Fund
- Home Health Aide Benefit Fund

This authorizes the Fund to disclose my Protected Health Information to the following person(s) named in Section C, upon request, for the purpose of their facilitating the receipt, coordination, or payment of my benefits.

Section A: Your Information (Person requesting the Fund to disclose Protected Health Information)

Member ID: _____ Date of Birth: _____/_____/_____
Month Day Year

Member Name: _____ Telephone: (_____) _____

Address: _____

City: _____ State: _____ Zip Code: _____

Section B: Member Information (If you are not the member)

Member ID: _____ Date of Birth: _____/_____/_____
Month Day Year

Member Name: _____ Telephone: (_____) _____

Address: _____

City: _____ State: _____ Zip Code: _____

Section C: Authorized Person(s)

I authorize the Fund to disclose my Protected Health Information to the following person(s), upon request:

Name of Authorized Person: _____ Telephone: (_____) _____

Address: _____

City: _____ State: _____ Zip Code: _____

Relationship to You: _____

Name of Authorized Person: _____ Telephone: (_____) _____

Address: _____

City: _____ State: _____ Zip Code: _____

Relationship to You: _____

Section D: Description of the Information to be Disclosed

The Protected Health Information that may be disclosed to facilitate the receipt, coordination, or payment of my benefits includes:

☐ All claims information, including medical, dental, vision, and prescription, and all eligibility information, including dates of coverage, limitations on benefits, etc.

☐ Other _____
(please be specific)

Section E: Rights Under HIPAA

I understand that:

- This authorization will automatically expire one year after the termination of my benefit coverage.
- I have the right to revoke or change this authorization **at any time** by completing, signing and submitting a Termination of Authorization Form to the Fund.
- My revocation will not apply to any action that has already been taken or any information that has already been released based on this authorization before receiving my revocation.
- I am entitled to receive a copy of this Authorization Form.
- If the person or entity I have named is not a healthcare provider, or otherwise subject to federal or applicable state privacy laws, my Personal Health Information may no longer be protected by those privacy laws and the named person or entity may further use or disclose my Protected Health Information without my authorization.
- Treatment, payment, enrollment and eligibility for benefits may not be conditioned on obtaining an authorization.
- I acknowledge that my authorization is voluntary.

Section F: Signature

Signature **X** _____ Date: _____

(Please read back for directions on how to complete this form).

Instructions to Help You Complete the Authorization Form

Please follow these instructions while completing the attached Authorization Form. Where applicable, answer each question completely.

If you need this information translated, please call our Member Services Department at (646) 473-9200. We have representatives who speak your language and will be happy to help you.

Si necesita esta información traducida, tenga la bondad de llamar a nuestro Departamento de Servicios para Miembros al (646) 473-9200. Tenemos representantes que hablan español, para los cuales será un placer ayudarle.

Если вам необходим перевод этой информации, просим позвонить в отдел обслуживания (Member Services) по телефону (646) 473-9200. У нас есть сотрудники, которые говорят на вашем языке и будут рады вам помочь.

如果你需要翻譯這資料，請致電我們的會員服務部門(646) 473-9200。我們有會説你語言的服務代表並且他們將會很高興地為你服務。

Section A: Your Information

In the spaces provided in Section A, please print your Member ID Number, date of birth, full name, telephone number and address.

Section B: Member Information

In the spaces provided in Section B, please print the Member's ID Number, date of birth, full name, telephone number and address. Without this information, we will be unable to track your authorization. If you are the member, simply write "same as above."

Section C: Authorized Person(s)

In the spaces provided in Section C, please print the name(s), of the person or persons to whom you authorize the Fund to disclose your Protected Health Information. This person will be able to call or visit the Fund or make inquiries on your behalf. Include that person's phone number, address and their relationship to you (for example, cousin, friend, union delegate, union representative, attorney, etc.).

If you want to authorize the Fund to be able to disclose your Protected Health Information to more than two individuals, please complete more than one form and submit them to the Fund.

Section D: Description of the Information to be Disclosed

If you want the individual to whom you are authorizing the Fund to release information to have access to all your information, please place an "X" in the first box. Place an "X" in the second box if you want the individual to have access only to specific information. In that case, please print the specific information you want the individual to have access to.

Section E: Rights Under HIPAA

Please read Section E, which explains when the authorization expires and your right to terminate or to change your authorization. Authorization Forms and Termination of Authorization Forms are available from the Fund by calling (646) 473-9200 or on the Fund's website: www.1199SEIUBenefits.org.

Section F: Signature

Please be sure to sign and date the form before mailing or delivering it to the Fund office.

Mail to: 1199SEIU Benefit and Pension Funds
Member Eligibility Department
PO Box 1035
New York, NY 10108-1035