1199SEIU Benefit Funds

Member Eligibility, PO Box 1035 • New York, NY 10108-1035 • Tel: (646) 473-9200 • Fax: (646) 473-8878 • www.1199SEIUBenefits.org

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Please print clearly in blue or black ink.
Please read reverse side for directions on how to complete this form.

• National Benefit Fund • Greater New York Benefit Fund • Home Care Benefit Fund • LPN Welfare Fund

This form authorizes the Fund to disclose your protected health information to the authorized person(s) named in Section C, upon request, for the purpose of facilitating the receipt, coordination or payment of your benefits.

SECTION A: YOUR INFORMATION (Person requesting the Fund to disclose protected health information)

MEMBER ID # DATE OF BIRTH

MEMBER'S FULL NAME PREFERRED PHONE

ADDRESS CITY STATE ZIP CODE

SECTION B: MEMBER INFORMATION (If you are not the member, fill out this section. If you are the member, write "Same as above.")

MEMBER ID # DATE OF BIRTH

MEMBER'S FULL NAME PREFERRED PHONE

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:

AUTHORIZED PERSON'S FULL NAME PREFERRED PHONE

ADDRESS CITY STATE ZIP CODE

RELATIONSHIP TO YOU: _____

AUTHORIZED PERSON'S FULL NAME PREFERRED PHONE

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, prescription and behavioral health, and all eligibility information, including dates of coverage, limitations on benefits, etc.

☐ Other (please specify): _____

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 submitting my revocation, in writing, 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 authorized person I have named is not a healthcare provider, or is 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 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.

X _____

MEMBER'S SIGNATURE **DATE**

3AF85 • 04/18 • AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Instructions to Help You Complete the Authorization Form

Please follow these instructions while completing the authorization form on the reverse side. 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。我們有會說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, preferred phone 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, preferred phone 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(s) to whom you are authorizing the Fund to disclose your protected health information. The person(s) will be able to call or visit the Fund or make inquiries on your behalf. Include each person's full name, preferred phone number, address, and his or her 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 persons, please complete more than one authorization form and submit them to the Fund.

Section D: Description of the Information to be Disclosed

If you want the authorized person(s) 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 authorized person(s) to have access only to specific information. In that case, please print the specific information you want the authorized person(s) to have access to.

Section E: Rights Under HIPAA

Please read Section E, which explains when the authorization expires and your right to revoke or change your authorization. Authorization forms are available from the Fund by calling (646) 473-9200, or by visiting the Fund's website at **www.1199SEIUBenefits.org.**

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

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

OR

Fax to: (646) 473-8878