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 instructions on how to complete this form.

This form authorizes the 1199SEIU Benefit Funds 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: MEMBER INFORMATION (The 1199SEIU member)

MEMBER ID # | DATE OF BIRTH

MEMBER'S FULL NAME | PREFERRED PHONE

ADDRESS | CITY | STATE | ZIP CODE

SECTION B: RECIPIENT INFORMATION (Person requesting disclosure of his/her protected health information. Must be age 18 or older. If you are the member, write "Same as above.")

RECIPIENT'S FULL NAME | PREFERRED PHONE

ADDRESS | CITY | STATE | ZIP CODE

SECTION C: I authorize the following person(s) to receive my protected health information from the Benefit Funds, upon request:

AUTHORIZED PERSON'S FULL NAME | RELATIONSHIP TO THE RECIPIENT

ADDRESS | CITY | STATE | ZIP CODE

AUTHORIZED PERSON'S FULL NAME | RELATIONSHIP TO THE RECIPIENT

ADDRESS | CITY | STATE | ZIP CODE

SECTION D: DESCRIPTION OF THE RECIPIENT'S 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 all eligibility information, including dates of coverage, limitations on benefits, etc.

For the following to be included, indicate the specific records to be disclosed:

☐ Alcohol/Drug treatment ☐ Mental health (including psychotherapy notes) ☐ HIV/AIDS-related information

☐ Other (please specify): _____

SECTION E: THE RECIPIENT'S RIGHTS UNDER HIPAA

I, the recipient, understand that:

- This authorization will automatically expire one year after the termination of my benefit coverage.
- I have the right to revoke this authorization **at any time** by submitting my revocation, in writing, to the 1199SEIU Benefit Funds.
- 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.
- If the authorized person I have named is not a healthcare provider, or is not 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. I am entitled to receive a copy of this authorization form.

X _____

RECIPIENT'S SIGNATURE **DATE**

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: Member Information

In the spaces provided, please print the 1199SEIU member's Member ID number, date of birth, full name (first and last name), preferred phone number and address. Without this information, the 1199SEIU Benefit Funds will be unable to track authorization.

Section B: Recipient Information

In the spaces provided, please print the recipient's full name (first and last name), preferred phone number and address. If the recipient is also the 1199SEIU member, just write “Same as above.”

Section C: Authorized Person(s)

In the spaces provided, please indicate the person(s) authorized to receive the recipient's protected health information from the Benefit Funds. The authorized person(s) will be able to call or visit the Benefit Funds or make inquiries on the recipient’s behalf. Print each person’s full name (first and last name), address and relationship to the recipient (for example, cousin, friend, Union delegate, Union representative, attorney, etc.).

If the recipient wants to authorize more than two people, please complete more than one authorization form and submit all forms to the Benefit Funds.

Section D: Description of the Recipient's Information to be Disclosed

If the recipient wants the authorized person(s) to have access to **all** information, please place an “X” in the first box. In order to release sensitive information regarding alcohol/drug treatment, mental health treatment (including psychotherapy notes) and/or HIV/AIDS-related information, the appropriate box(es) must be marked with an “X.”

If the recipient wants the authorized person(s) to have access only to **specific** information, place an “X” in the box marked “Other” and list the specific information.

Section E: The Recipient's Rights Under HIPAA

Please read this entire section, which explains when the authorization expires and the recipient's right to revoke his or her authorization. Authorization forms are available from the Benefit Funds by calling (646) 473-9200, or by visiting the Benefit Funds’ website at **www.1199SEIUBenefits.org.**

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

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

OR

Fax to: (646) 473-8878