District Council No. 3 Painters and Allied Trades Welfare Fund:

Authorization Form

_____

[A separate authorization must be used if the authorization is for psychotherapy notes.]

Individual Name: _____ Social Security #_____

Participant Name: _____ Social Security # _____

Address: _____

_____

Home Telephone Number: _____ E-mail: _____

Work Telephone Number: _____

By signing this authorization form I authorize the person(s) and/or organizations(s) described below to use and/or disclose my protected health information (PHI) as defined in the federal Privacy Rule in the manner described below. I understand that I am under no obligation to sign this form. I have signed this form voluntarily to document my wishes regarding the use and/or disclosure of the PHI described below in Section 1 of this form.

1. Description of Health Information I Authorize to be Used or Disclosed. The following is a specific description of the PHI I authorize be used and/or disclosed: (Specify and provide a meaningful description.)

_____

_____

_____

2. Persons/Organizations Authorized to Use and/or Disclose My Health Information. I authorize the District Council No. 3 Painters and Allied Trades Welfare Fund to use and/or disclose the PHI described above in Section 1 of this form.

3. Persons/Organizations Authorized to Receive and/or Use My Health Information. I authorize the following person(s) and/or organization(s) (or classes of persons and/or organizations) to receive my PHI from the District Council No. 3 Painters and Allied Trades Welfare Fund and to use or disclose such information for the purposes listed below in Section 4 of this form. I understand that if the person(s) and/or organization(s) listed below are not health care providers, health plans or health care clearinghouses subject to federal privacy standards, the PHI disclosed pursuant to this authorization may no longer be protected by the Privacy Rule and such person(s) and/or organization(s) may re-disclose my PHI without obtaining my authorization.

_____

_____

_____

4. Description of Each Purpose for the Requested Use and/or Disclosure. I authorize my PHI to be used and/or disclosed for the following specific purposes:

_____

_____

_____

5. Your Rights with Respect to This Authorization.

5.1 Right to Revoke. I understand that I have the right to revoke this authorization at any time. I also understand that my revocation of this authorization must be in writing. To obtain a copy of an authorization revocation form I may contact **District Council No. 3 Painters and Allied Trades Welfare Fund, PO Box 909500, Kansas City, MO 64190-9500 (816) 756-3313.** I am aware that my revocation will not be effective as to uses and disclosures of my PHI that the person(s) and/or organization(s) identified in Sections 2 and 3 of this form have already made in reliance upon this authorization.

5.2 Right to Receive a Copy of This Authorization. I understand that if I agree to sign this authorization, which I am not required to do, I must be provided with a signed copy of it.

6. Expiration of Authorization. This authorization will expire (choose and complete one):

☐ On _____/_____/_____.
MM DD YR

OR

☐ Upon the occurrence of the following event(s) related to my health care or to the purpose(s) for which I have authorized the use and/or disclosure of my health information described in Section 4 of this form:

_____

_____

I, _____ (please print name) have had an opportunity to review and understand the contents of this form. By signing this form, I am confirming that it accurately reflects my wishes.

_____ _____/_____/_____
Individual Signature Date

If signed by a personal representative, complete the following:

Name of personal representative: _____

Relationship to participant or nature of authority (e.g., health care power of attorney, guardian, other statutory authorization): _____

Address: _____

_____

Home Telephone Number: _____ E-mail: _____

Work Telephone Number: _____

_____ _____/_____/_____
Signature of Personal Representative Date

Submit Form to: Board of Trustees, c/o Wilson-McShane Corporation, PO Box 909500, Kansas City, MO 64190-9500, Telephone (816)756-3313