New York City District Council of Carpenters Welfare Fund

Authorization Form for Release of Medical Information

I ______________________ hereby authorize the use or disclosure of my health information as described in this authorization.

1. Specific person/organization *(or class of persons)* authorized to provide the information:

   New York City District Council of Carpenters Welfare Fund

2. Specific person/organization *(or class of persons)* authorized to receive all of the below information:

   ____

3. Specific and meaningful description of the information:

   Please check the applicable box or describe the information you wish the Fund to disclose:

   Copy of Birth Certificate Copy of Marriage Certificate
   Written, electronic and oral information related to eligibility for benefits for the time period commencing on ___________ and continuing through ___________.
   Written, electronic and oral information including claims, reports, and other documents related to claims for benefits for an injury or illness commencing on ____ _______ and continuing through _________
   Other: _____________ ____

4. ***Purpose of the request:*** Please state the purpose of the request below. If you do not wish to state a purpose, please state, “At the request of the individual.” The Fund will forward authorization to the appropriate parties. ______________________________

5. ***Right to Revoke:*** I understand that I have the right to revoke this authorization at any time by notifying New York City District Council of Carpenters Welfare Fund in writing at 395 Hudson Street, New York, NY 10014. I understand that the revocation is only effective after it is received and logged by the Fund. I understand that any use or disclosure made prior to the revocation under this authorization will not be affected by a revocation.
6. I understand that after this information is disclosed, federal law might not protect it and the recipient might disclose it again.
7. I understand that I am entitled to receive a copy of this authorization.
8. I understand that this authorization will **expire within one year** of the date of this authorization is signed.
9. The Fund will not condition treatment, payment, enrollment or eligibility for health plan benefits on receipt of an authorization.

_______________________ _____________________

Signature of Individual Date

____

Address

If a Personal Representative executes this form, that Representative warrants that he or she has authority to sign the form on the basis of:

This authorization reflects the requirements of 45 C.F.R. § 164.508 (August 14, 2002, as updated by HITECH, January 25, 2013)