## Alaska United Food & Commercial Workers Trust Funds

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Administered by Welfare & Pension Administration Service, Inc.

## AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

Nam	e:	Birth Date: _	/	/	-
Addr		Home Telephone No.: Work Telephone No.: E-mail Address:			
Last	4 digits of the Covered Employee's	Social Security Number:			
PUR	POSE OF AUTHORIZATION				
Healt infor opera Auth caref	th Plan to release health information mation, or to use or disclose heal ations (e.g., treatment, payment of corization will rely on it to use and fully.  FURE OF DISCLOSURE BEING		ial whe is the is	o is the sub Health Plar he recipien ion. Please	oject of the n's normal ats of this e review it
The effec		s 1 through 7 must be provided for	or this	s Authoriza	tion to be
1.		<b>Disclosed</b> : Identify here what you ld be specific such as "Information re			
	List information here:				
2.		sclosure: List why the information is apply list "At the request of the individual"		g disclosed.	If you are
	List purpose:				

	<b>Identify Who Is Authorized to Disclose the Information:</b> Identify here who is authorized to make the disclosure. Be specific such as the "Trust Office." Check each box which applies		
	<ul> <li>□ All entities with information about the matters listed in Questions 1</li> <li>□ Only the following entities:</li></ul>		
	Who Will Receive the Information: List here who is authorized to receive information "Mary Jones, my spouse" or "John Doe, my union representative."		
List add	W How To Provide Information: Where and how should the information be disclosed? dress, e-mail, facsimile, etc. Please remember that the information being sent is your health information.		
<b>Expiration Date of Authorization:</b> Indicate when your authorization will end. This can be a date ("December 31, 2004") or the happening of an event ("when decision is reached on my appeal"). Unless otherwise indicated this authorization will be good for one year.			
Choose	and complete one:		
a.	□ On//		
b.	☐ Upon the occurrence of the following event:		
Signatu	Signature and Date: This document must be signed and dated.		
Cianatu			
Signatui	re and Date:		

## STATEMENT OF RIGHTS REGARDING THIS AUTHORIZATION

<u>General Rights</u>. I understand I am not required to sign this form and that a Covered Entity receiving it cannot condition treatment, payment or eligibility on my decision to sign this form. I understand, however, that a health plan can condition enrollment in the Plan or eligibility for benefits on receiving an authorization if the purpose is to allow the health plan to obtain information it needs to make an eligibility, enrollment or underwriting decision and psychotherapy notes are not requested.

<u>Right to Revoke</u>. I understand that I have the right to revoke this authorization in writing except as to uses and/or disclosures already made in reliance on it. Authorization revocation forms can be obtained by contacting the Contact Person listed in my Health Plan's Privacy Notice.

**Effect of Disclosure.** I understand that if the persons to whom my health information is disclosed are not subject to the HIPAA Privacy Rule (i.e. are not a health plan, health care provider or health care clearinghouse), the disclosed health information may no longer be protected by the HIPAA Privacy Rule and may be redisclosed without my authorization.

**Retention and Right to Copy.** I understand that a Covered Entity which receives this Authorization must retain a copy and that I am required to receive a signed copy as well.

<u>Provisions Related to Psychotherapy Notes.</u> I understand that an Authorization is required for any use or disclosure of psychotherapy notes except in the limited situations dealing with treatment, training or defense of legal actions as defined in 45 CFR 164.508(a)(2).

**Records Related to STD, or Alcohol or Chemical Dependency.** I understand that if the health information that I have authorized be disclosed under Question 1, includes information regarding testing, diagnosis or treatment for HIV/AIDS, sexually transmitted diseases, or drug or alcohol use, that I am authorizing the disclosure of this information.

## PERSONAL REPRESENTATIVE

This section only needs to be answered if this authorization is being completed by someone other than the individual who is the subject of the health information.

The Health Plan, for purposes of the Privacy Rule will treat a properly designated personal representative as the individual without the need for an authorization. This will apply when the individual is deceased, a personal representative has been designated in accordance with applicable law, or the individual is an unemancipated minor and state law does not prohibit disclosure to a parent or other guardian. The Health Plan reserves the right to decline to recognize an individual as a personal representative if there is a reasonable belief that the individual whose information would be disclosed has been or could be subject to abuse, neglect or endangerment by disclosure. Disclosure also will not be made if inconsistent with applicable law.

Except as limited by state law of the Privacy Rules, no authorization is needed to disclose information to a natural parent or legal guardian of an unemancipated minor.

a.	Name of Personal Representative:				
b.	b. Basis for Being Personal Representative (e.g. parent, executed health care power attorney, etc.) Attach a copy of any document creating your authority to act for named individual.				
Address:	Telephone No.:				
<del>-</del>	E-mail Address:				
Signature: _	Date:				
CR:NK/adg opeiu#8 S:\Forms\HIPAA\F45\F45 - 04/18/2017	Authorization - 2017.doc				