UNITED FOOD AND COMMERCIAL WORKERS UNION LOCAL 152 HEALTH AND WELFARE FUND

BRIAN STRING, Chairman
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27 ROLAND AVENUE, SUITE 100, MOUNT LAUREL, NJ 08054-1056

(856) 793-1598 (TTY:711) • (800) 555-4959 (TTY:711) • Fax (856)793-3100

SUBJECT: HIPAA AUTHORIZATION FORM

To provide you with the benefits to which you are entitled, the UFCW LOCAL 152 H&W (the "**Fund**") must collect, create and maintain information about you. We at the Fund are concerned about the privacy of this information which is referred to as "**Protected Health Information**" or "**PHI"** under the Health Insurance Portability and Accountability Act of 1996 ("**HIPAA**"). To protect PHI, HIPAA requires health plans such as the Fund to set up new policies and procedures regarding how they use and disclose information about participants such as you.

The Notice of Privacy Practices that has been mailed to all members of the Fund's health plans describes how the Fund may use and disclose Protected Health Information about you, as well as the Fund's obligations and your rights with respect to that information. If you would like another copy of the Notice of Privacy Practices, you may request one by calling the Fund Office at 856-793-1598 (TTY:711).

HIPAA establishes limits on those with whom the Fund can discuss your Protected Health Information when you are not present for the conversation. These limits include information regarding your eligibility and the eligibility of your covered dependents, treatment dates and the reasons for any denial of benefits. If you want to authorize the Fund Office to discuss this type of Protected Health Information with another person, **including your spouse, or a business agent, or other staff member of a Local Union or District Council**, you must complete the Fund's standard Authorization Form, attached hereto. Generally, you will not need an authorization to obtain Protected Health Information about your minor children, with some exceptions. However, you will need an authorization to obtain Protected Health Information about covered dependents that are adults.

You may obtain additional information regarding authorizations by writing to Privacy Officer, Frank M. Vacarro, Jr., Esq., 27 Roland Avenue, Suite 200, Mt. Laurel NJ 08054.

(Updated May 2014)

UFCW LOCAL 152 Health & Welfare Fund

Authorization Form

Your Name: _____ Birth Date: _____/_____/____
Please Print (Your Signature will be Required Below) MM DD YY

Your relationship with Participant: ❑Self ❑Spouse ❑Dependent Child
Participant's Name:
_____
Participant's Social Security Number or Member Number:
_____
Address:
_____
_____

Home Telephone Number: _____ Work Telephone Number: _____

I hereby authorize the UFCW Local 152 H&W (the "Fund") to use and/or disclose my Protected Health Information as follows:

1. **Information to be Used or Disclosed.** The following Protected Health Information (PHI) may be used and/or disclosed as described below (Check those that apply):

- ❑ Any health care information that you have about me.
- ❑ Any information that relates to my eligibility for benefits provided by the Fund.
- ❑ The dates of treatment that I received.
- ❑ The reason(s) that I was denied benefits.
- ❑ Other [Please describe the information in specific and meaningful fashion]

_____
_____

2. **Persons to Whom the Use or Disclosure May be Made.** The following person(s) or class of persons may receive the Protected Health Information described in Section 1 of this Authorization from the Fund Office and/or UFCW Local 152 H&W Fund.

- ❑ Spouse's Name: _____
- ❑ Child(ren)'s Name(s): _____
- ❑ Parent(s)' Name(s): _____
- ❑ Business Agent or other staff member of Local Union or District Council
- ❑ Other Name: [List the name or specific identification of the person or classes of persons]

_____
_____

If you only want your PHI released to someone who knows a password, write your password here:
_____.

3. **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."

_____
_____
_____

4. **Expiration Date or Event.** This authorization will expire (choose and complete one):

❑ Ten years from the date this authorization is signed

❑ On _____/_____/_____ (Less than 10 years from the date authorization is signed)
MM DD YY

❑ 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 Protected Health Information:

_____
_____
_____

I understand that:

(1) I may revoke this Authorization in writing at any time except to the extent that the Fund has taken action in reliance on this Authorization;
(2) The Fund may not condition treatment, payment, enrollment or eligibility for benefits on my willingness to sign this Authorization; and
(3) Any information disclosed under this Authorization may be subject to redisclosure by the recipient and may no longer be protected by law.

By: _____ Date: _____
[Your Signature]

Please return to the Fund Office at 27 Roland Avenue, Suite 100, Mt. Laurel, NJ 08054, or by fax to 856-793-3100.