Twin City Iron Workers Health & Welfare Fund

Authorization for Release of Protected Health Information (PHI) By the Fund

You MUST complete all of the information requested in this form for your authorization to be valid.

I authorize the Plan the use of disclosure of my Protected Health Information (PHI) as described in this authorization. I understand the Plan may not condition my treatment, payment, enrollment or eligibility for benefits on whether or not I give the authorization listed in this form.

(1) **The Plan can release PHI to:** The Plan, its agents or subcontractors ("Business Associates") is authorized to release the PHI described below to the following person, class of persons, or organization:

- ☐ My spouse
- ☐ My Union
- ☐ My parents
- ☐ My Employer
- ☐ Other (Print Name or Position): _____

(2) **The information that may be used or released is:**

- ☐ Medical information held by the Plan from the following doctor, clinic, or hospital:

_____

- ☐ Information held by the Plan concerning my eligibility, claims decisions and payments.
- ☐ Other. Please specify below.

_____

(3) **Right to revoke:** I understand that I have the right to revoke this authorization at any time by notifying the Plan's Contact Person in writing at the address listed at the top of this Form. I understand that the revocation is only effects after it is received and logged by the Plan. I understand that any use or disclosure made prior to the revocation under this authorization will not be affected by a revocation.

(4) **Re-Release of Information:** I understand that after this information is released, federal law might not protect it and the recipient might re-release it I also understand and agree to hold the Plan and any of its agents and subcontractors harmless if the information is re-released.

(5) **Copy:** I understand that the Plan will give me a copy of this authorization

(6) **THE AUTHORIZATION WILL EXPIRE ON THE DATE ON WHICH YOUR ELIGIBILITY UNDER THE PLAN TERMINATES UNLESS YOU SPECIFY ANOTHER DATE OR TERMINATION EVENT BELOW.**

- ☐ Other: _____

Your Signature:_____ Date: _____

Print Your Name: _____

If you are covered under the Plan as a Dependent, please print the name and social security number of the covered employee:

Name: _____ SSN: _____

Mail or Fax Completed Forms to the Fund Administrator:

3001 Metro Drive – Suite 500, Bloomington, MN 55425
Fax: 952-851-3521