

AUTHORIZATION
FOR RELEASE OF PROTECTED HEALTH INFORMATION

I authorize the use and disclosure of my protected health information as described below. My protected health information is individually identifiable health information, including demographic information, collected from me or created or received by a health care provider, a health plan, my employer, or a health care clearinghouse and that relates to: (i) my past, present, or future physical or mental health or condition; (ii) the provision of health care to me; or (iii) the past, present, or future payment for the provision of health care to me.

In order to process your request to release your Protected Health Information, please complete the following information and return this form to:

Client Services Department
Western States Health & Welfare Trust Fund of the OPEIU
1220 S.W. Morrison St., Suite 300
Portland, OR 97205

Please contact us at (503) 224-0048 or (800) 547-4457 if you have any questions.

INDIVIDUAL DATA:

PARTICIPANT'S NAME: _____

NAME OF GROUP HEALTH PLAN: _____

GROUP HEALTH PLAN ID NUMBER OR SOCIAL SECURITY NUMBER:

DATE OF BIRTH: _____

ADDRESS: _____

TELEPHONE NUMBER: _____

Relationship to Employee: Self Dependent

If you are a covered dependent, please provide the employee information below:

Employee Name: _____

Employee Plan ID Number or Social Security Number: _____

The following individual is authorized to use or disclose my protected health information:

The following individual is authorized to receive my protected health information:

The protected health information that may be used and disclosed is as follows:

[Describe in as much detail as possible the protected health information that you wish to be used or disclosed. For example, the information to be used or disclosed may relate to payment, enrollment, or claims. If so, you should include, if available, the types of claims, dates of service, or types of service.]

My protected health information will be used or disclosed for the following purpose(s):

[Describe the reason for each use and disclosure of the protected health information. If an individual initiates the authorization for his or her own purposes, insert "at the request of the individual."]

I understand that I may refuse to sign this authorization. I further understand that Western States Health & Welfare Trust Fund of the OPEIU will not condition enrollment or eligibility for benefits on my signing this authorization.

I understand that I may revoke this authorization at any time by sending a written notification to Western States Health & Welfare Trust Fund, at 1220 S.W. Morrison St, Ste 300, Portland, OR 97205, and this revocation will be effective for future uses and disclosures of protected health information. However, I further understand that this revocation will not be effective: (i) for information that Western States Health & Welfare Trust Fund already has used or disclosed, relying on this authorization .

This authorization expires [identify a specific date or event]: _____

Participant Name (Print or Type)

Employee Name, if different than Participant Name (Print or Type)

Name of Personal Representative (if applicable)

Signature of Participant or Personal Representative

Date

Description of Personal Representative's Authority and Telephone Number