

AUTHORIZATION FORM

Participant/Eligible Dependent Name: _____ **Birth Date:** ____/____/____
MM/DD/YR

Address: _____

Home Telephone Number: _____ **E-mail:** _____
Work Telephone Number: _____

Participant Social Security Number: _____

By signing this authorization form ("Authorization") I authorize the AFTRA Health Fund ("Fund") to disclose my Protected Health Information ("PHI").¹ I have signed this Authorization voluntarily to document my wishes regarding the disclosure of the health information described below in Section 1 of this form.

1. I Authorize the Following PHI to be Disclosed:

- Eligibility/Enrollment Information
- Claims Records
- Claims Status Information
- Other (specify) _____

2. Persons/Organizations Authorized to Receive My Health Information. I authorize the Fund to disclose to the following person(s) and/or organization(s) (or classes of persons and/or organizations) my PHI described in Section 1 above and to disclose such information for the purposes listed below in Section 3 of this Authorization. I understand that if the person(s) and/or organization(s) listed below are not health care providers, health plans or health care clearinghouses subject to federal privacy standards, the health information disclosed pursuant to this Authorization may no longer be protected by the federal privacy standards and such person(s) and/or organization(s) may redisclose my health information without obtaining my authorization.

Name: _____

Address: _____

3. I authorize my health information to be disclosed for the following specific purposes:

- Medical Care
- Insurance/Eligibility and Benefits
- Legal Investigations or Action
- At my personal request

4. Your Rights with Respect to This Authorization.

Right to Revoke. I understand that I have the right to revoke this Authorization at any time. I also understand that my revocation of this Authorization must be in writing. To obtain a copy of an Authorization Revocation Form I may contact the Plan's Privacy Officer at the address listed at the end of this Authorization. I am aware that my revocation will not be effective as to disclosures of my PHI that have already been made in reliance upon this Authorization to the person(s) and/or organization(s) identified in Section 2 of this Authorization.

Right to Receive Copy of This Authorization. I understand that if I sign this Authorization, I will be provided with a signed copy.

¹ Information that constitutes PHI as defined in the Privacy Rule of the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") in the manner described above.

