**AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION**

**Section A: Member / Claim Information**

**Patient Name:** _____ **Member Name:** _____

**Member ID Number:** _____

**Section B: Authorized Use and / or Disclosure**

**Intended Use or Disclosure:**
I understand that the Welfare Fund, pursuant to new privacy laws, may not generally disclose my health information without my written authorization to my family members or other individuals that I may want to have access to my health information. For this reason, I authorize District No. 9, I.A.M.A.W. Welfare Fund to discuss and disclose my health information that is maintained by the Fund to the person(s) that I have named below.

I understand that I have the right to limit the information that the Fund releases under this authorization. For example, I may limit my Authorized Representative's access to information about a particular health care provider or a particular diagnosis/disease. Any such limitations must be described below in writing. I understand that by leaving this section blank, I am creating no limitations on disclosure.

**Limitations on Disclosure:** _____

_____

**Authorized Representative #1:**

**Name:** _____ **Phone Number:** _____

**Address:** _____ **Zip:** _____

**Relationship to You:** _____

**Authorized Representative #2:**

**Name:** _____ **Phone Number:** _____

**Address:** _____ **Zip:** _____

**Relationship to You:** _____

**Section C: Expiration**

This authorization to release information to my Authorized Representative will automatically expire upon a lapse of my enrollment in the plan for a period of two consecutive years.

**Section D: Important Information Concerning Your rights**

1. You may revoke this Authorization at any time. However, any revocation will not apply to the extent that we have already taken action in reliance upon your Authorization. Your request for revocation must be in writing. We will provide you with a revocation form at your request.
2. We may not condition the provision of treatment, payment, enrollment in a health plan, or eligibility for benefits upon your signing this Authorization.
3. Information used or disclosed pursuant to this Authorization may be subject to redisclosure by the recipient and may no longer be protected by Federal health information privacy laws.
4. You are entitled to a signed copy of this Authorization.

**Section E: Signature / Authorization**

I have had full opportunity to read and consider the content of this Authorization. I confirm that this authorization is at my request. I understand that, by signing this form, I am confirming my authorization that the health plan may use and/or disclose my personal health information to the person(s) named in Section B.

**Signature:** _____ **Date:** _____

**PLEASE RETURN THE SIGNED AUTHORIZATION FORM TO THE WELFARE FUND AT:**

**DISTRICT NO. 9, I.A.M.A.W . WELFARE FUND, 12365 ST. CHARLES ROCK ROAD, BRIDGETON, MO 63044**
**314-739-6442 • 888-739-6442**