



IBEW LOCAL UNION NO. 22/NECA
HEALTH and WELFARE TRUST FUND
www.ibew22benefits.com

Electrical Industry Center
8960 L Street, Suite 101
Omaha, NE 68127-1414
Telephone: (402) 592-3753
Toll Free: (866) 315-1739
Fax: (402) 951-9500

PROTECTED HEALTH INFORMATION (PHI) AUTHORIZATION FORM

SECTION A: Individual authorizing use or disclosure

NAME: _____ SUBSCRIBER ID NUMBER: _____

TELEPHONE: (Day) (____) _____ (Evening): (____) _____

ADDRESS: _____
Street Apartment #
City State Zip Code

SECTION B: Scope of authority

I hereby authorize the IBEW 22/NECA Health & Welfare Fund ("the Plan") to use or disclose my Protected Health Information (PHI) as described in this authorization. I understand that my PHI may include, but is not limited to, the following: medical records, emergency care records, billing statements, Explanation of Benefits, diagnostic imaging reports, transcribed hospital reports, laboratory reports, dental records, pathology reports, physical therapy records, hospital records (including nursing records and progress notes), claim status, claim information, confirmation or denial that treatment has occurred, treatment information, information on my physical or mental condition, and any personal or medical information related to the purpose of this authorization.

I further understand that my PHI may include information related to any of the following: genetic testing, mental health (excluding psychotherapy notes), HIV/AIDS, prescription medication, pregnancy, maternity, organ transplants, and chemical dependency (including alcohol and drug treatment). I authorize the use and/or disclosure of my Protected Health Information as indicated below.

SECTION C: Persons/Organizations authorized to use or disclose my PHI

The following individuals or organizations are authorized to **RELEASE** my PHI. (Please include addresses and phone numbers, if known):

_____.

The following individuals or organizations are authorized to **RECEIVE** my PHI. (You **MUST** include the Social Security Number or Employer Identification Number of each recipient, as well as your relationship to the recipient. In addition, please include addresses and phone numbers, if known):

_____.

If you wish to place any conditions or limitations upon this authorization, please describe. (If you do not identify any conditions or limitations, the Plan will assume it may use or disclose all of your PHI within the scope of its authority, as set forth in Section B, above.):

I understand that this authorization will expire on the following date: _____ **OR** upon the occurrence of the following event (e.g., loss of plan eligibility): _____, whichever comes first.

SECTION D: Terms and conditions of this authorization

I understand that I may refuse to sign this authorization. I understand that the Plan may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization. I further understand that if the person(s)/organization(s) authorized to receive my PHI are not health plan or health care providers, the disclosed information may no longer be protected by federal privacy regulations. I also understand that I may revoke this authorization at any time, in writing, except to the extent that action has been taken in reliance upon this authorization. Unless revoked earlier, this authorization will expire on the date or event specified above or upon disenrollment from the Plan.

SECTION E: Purpose of authorization

Purpose for which use or disclosure is authorized (NOTE: You are not required to provide a specific purpose; if left blank, the Plan will presume that the use or disclosure is simply being made at your request):

SECTION F: Signature

Signature of Individual

Date

If this authorization is signed by a personal representative on behalf of the subscriber, please complete the following:

Personal Representative's Name: _____

Relationship to the subscriber (e.g., parent, guardian,* or attorney-in-fact*): _____

* Please attach legal documentation if you are the legal guardian or attorney-in-fact.

Please return completed and signed form to the following address:

IBEW 22/NECA Health & Welfare Fund

Attn: Privacy Officer

8960 "L" Street, Suite 101

Omaha, NE 68127-1414

If you have questions, or need additional information or assistance in completing this form, please contact us at (402) 592-3753.