Heat and Frost Insulators Local 34 Health & Welfare Trust
3001 Metro Drive, Suite 500 · Bloomington, MN 55425 · P: 952·851·5948 · F: 952·854·1632

Dear Member,

Please fill out the enclosed PHI form allowing us to speak to whomever you designate under section 1. Without this form, we cannot give out any information pertaining to your medical coverage (i.e. deductibles, claims, etc.). This form will need to be filled out by **anyone over the age of 18**.

How to fill out section 2 of this form – <u>YOU ONLY NEED TO CHOOSE 1 OPTION</u>:

- **By choosing the first option, the most common option chosen, you are allowing us to speak to whomever is designated on this form on behalf of your medical PHI.**

- **By choosing the second option, you will need to list every doctor, clinic, etc. that will allow us to speak to whomever is designated on this form.**

If you have any questions regarding this form, please feel free to contact our office at 952-854-0795. The benefits office hours are Monday through Thursday, 8:00 AM to 5:00 PM.

Please return this form in the enclosed envelope or fax at 952-854-1632.

Thank you,

Wilson McShane Corporation
3001 Metro Drive, Suite 500
Bloomington, MN 55425

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Authorization for Release of Protected Health Information (PHI)

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 parents
- □ My Union
- □ 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 in effect 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: _____