Automatic Sprinkler Local 281, U.A. Welfare Fund
11900 South Laramie Avenue
Alsip, Illinois 60803
(708) 597-1832 Fax (708) 597-1894

AUTHORIZATION FORM
(For Use or Disclosure of Protected Health Information)

PURPOSE OF THIS FORM

In order for the Automatic Sprinkler Local 281, U.A. Welfare Fund ("Fund") to use or disclose Protected Health Information to someone other than you, you must complete this Authorization Form and return it to the Fund.

Protected Health Information ("PHI") is information that is created, received, transmitted or stored by the Fund which relates to your past, present, or future physical or mental health, health care, or payment for health care, and either identifies you or provides a reasonable basis for identifying you. Except as permitted by law, the Fund may not use or disclose PHI to persons other than those you specify on this form.

The Fund may request that you complete this form where the use or disclosure of information is necessary to carry out functions of the Fund. In addition, you may submit this form to the Fund because you want someone to request or receive your PHI from the Fund. This form is not needed if you are requesting your own PHI from the Fund. The Fund has a separate form for that type of request.

_____	_____	_____
Print your name	Participant's name (if different)	Participant's SSN

PART I: Authorized Person(s)

I authorize the Fund to disclose the PHI identified in Part II of this form to the following person(s): Please fill in their name, address, and relationship (for example; spouse, parents, business manager, attorney).

_____		
Name	Address	Relationship
_____		
Name	Address	Relationship
_____		
Name	Address	Relationship

PART II: Description of the information to be used or disclosed

I authorize the Fund to disclose PHI (including written, electronic, or oral information) to the person(s) identified in PART I of this form in connection with (mark all that apply): (If you want different people to have access to different information, you must fill out separate forms.)

___All Claims and Eligibility Information
___Specific Medical, Dental, Vision, or Other Claim for Health Benefits
Provider: _____ Date(s) of Service: _____
___Other (please be as specific as possible) _____

PART III: Purpose of use or disclosure

The purpose(s) for which the individual(s) named in Part I of this Authorization Form may have access to my PHI is as follows: (Mark all that apply or specify another purpose, for example, "subrogation"). If you do not wish to specify, check "I am requesting disclosure of PHI for my own reasons."):

___All matters concerning eligibility for benefits and the status/payment of claims.
___Other purpose (please state what the purpose is):
___I am requesting disclosure of PHI for my own reasons.

PART IV: How long this form is valid

This Authorization form is valid for as long as I am covered by the Plan unless I cancel form or specify another date or event below.

_____ (please provide date or event)
(Examples: "January 1, 2006" or "Until the issue raised in PART II is resolved"

PART V: Acknowledgment and Signature

I understand that:

- **The Fund will provide a copy of this signed Authorization Form to me.**
- **I have the right to refuse to sign this Authorization Form.**
- **I have the right to revoke this form at any time by submitting a Cancellation of Authorization Form to the Fund.**
- **Cancellation will take effect as to the cancellation date or event, or once the Fund receives the Cancellation of Authorization Form.**
- **The person(s) I am authorizing to receive my PHI is not required to treat this information as confidential and the information disclosed is no longer required to be treated as protected health information.**

_____ _____
Your Signature (or Signature of Personal Representative*) Date

*If you are acting as the Personal Representative of the individual whose PHI is to be disclosed, you must provide proof of your authority to act for that individual.