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

FAMILY 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 your Protected Health Information (PHI) to someone other than you, you must complete this Authorization Form and return it to the Fund. The Fund may request that you complete this form where you wish the Fund to disclose your PHI to a family member. The Fund has a separate form if you wish to have your PHI disclosed to other persons.

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

PART I: I authorize the Fund to disclose my protected health information (PHI) identified in Part II of this form to the following person(s). Please include names:

☐ Spouse _____ ☐ Parent(s) _____

PART II: I authorize the Fund to disclose my protected health information (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):

☐ All claims information for benefits covered under the Plan all eligibility information.

☐ Other (please be as specific as possible) _____

PART III: The purpose(s) for which the individual(s) named in Part I of this Authorization Form may have access to my PHI is for assistance with claims payment, eligibility, appeals.

PART IV: This Authorization Form is valid. (Please choose one.):

☐ For as long as I am eligible for benefits from the Fund or ☐ until _____.
(Specify date or event.)

PART V: I understand that:

- **THE FUND WILL PROVIDE A COPY OF THIS SIGNED AUTHORIZATION 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 OF 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 MAY NOT BE REQUIRED TO TREAT THIS INFORMATION AS CONFIDENTIAL.**

_____	_____
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.