UFCW NATIONAL FUND
small enough to care...BIG enough to make a difference!®

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AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Participant Information:

Name: ______________________ Date of Birth (D.O.B.): ______________________

Member ID: ______________________

Authorization to Disclose Protected Health Information

I, the undersigned participant, authorize The UFCW National Health and Welfare Fund ("the Plan") to disclose my protected health information (PHI) to the individuals listed below. This information may include, but is not limited to, medical diagnoses, treatment history, claims, and benefits information.

Authorized Individuals:

1. Name: ______________________ **2.** Name: ______________________

Relationship: ______________________ Relationship: ______________________

This authorization applies to the protected health information of:

☐ Myself (Member) ☐ My Dependent: Full Name D.O.B.

I authorize disclosure of the following information related to the above-named dependent:

☐ Eligibility and coverage ☐ Medical records ☐ Other (please specify):

☐ Claims and billing ☐ All the above ______________________

Purpose of Disclosure:

This authorization allows the above-listed individuals to access my health information for the purpose of assisting with my healthcare, claims, benefits, and other related matters.

Acknowledgment and Consent:

I understand that:

- This authorization is voluntary and can be revoked at any time by submitting a written request.
- The information disclosed may be subject to re-disclosure by the authorized recipients and may no longer be protected under HIPAA.
- This authorization remains in effect until I revoke it in writing or upon my termination from the Plan.

Participant Signature:

Signature: ______________________

Date: ______________________

FOR PLAN USE ONLY:

Received by:

Date:

Processed by:

Date: