NATIONAL IAM
BENEFIT TRUST FUND

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

PURPOSE OF THIS FORM

In order for the National I.A.M. Benefit Trust Fund ("Fund") to use or disclose your 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, such as your spouse or union representative, to request or receive your PHI from the Fund. This form is not needed if you are requesting your own PHI from the Fund. **All sections of this Form must be completed.**

Name of Individual Giving Authorization (Please Print) _____ Social Security Number _____

If you are a dependent of a covered employee/member, please provide the name and Social Security Number of the covered employee/member.

Name of Covered Employee/Member _____ Social Security Number _____

PART I: Authorized Person(s)

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

1. Name: _____ Relationship: _____
   Address: _____
2. Name: _____ Relationship: _____
   Address: _____

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

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): (If you want different people to have access to different information, you must fill out separate forms.)

- ☐ All Claims information for any dates of service
- ☐ Medical Claims only for the following dates: From: _____ To: _____
- ☐ Dental Claims only for the following dates: From: _____ To: _____
- ☐ Vision Claims only for the following dates: From: _____ To: _____
- ☐ Specific Medical, Dental, Vision, or Other Claim for Health Benefits (as noted below):
  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):

☐ Health care claims or appeals	☐ Payment for health care	☐ Coverage
☐ Coordination of benefits	☐ Health care claim status	☐ Preauthorization
☐ Eligibility in the Fund	☐ Premiums and co-payments	
☐ Subrogation and reimbursement	☐ I am requesting disclosure of PHI for my own purposes	

☐ Other purpose (explain): _____

PART IV: Effective Period of the Form

This Authorization Form is valid for the period designated below **(check only one box; if you check more than one box, the Authorization Form will be valid only for the shortest period selected)**:

☐ For as long as I am eligible for benefits under this Plan

☐ Only until the information requested on this form is provided to the individual identified on this form.

☐ Until: _____ (please provide a date or event)

You may also cancel this authorization at any time, no matter which option you select above, by submitting to the Fund office a properly completed **Cancellation of Authorization Form**. Forms are available from the Fund office.

PART V: Acknowledgment and Signature

I understand that:

- **THE FUND WILL PROVIDE A COPY OF THIS SIGNED AUTHORIZATION FORM TO ME OR MY PERSONAL REPRESENTATIVE.**
- **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.