TEAMSTERS LOCAL 170 HEATLH & WELFARE FUND
PARTICIPANT AUTHORIZATION FORM

[A separate authorization must be used if the authorization is for psychotherapy notes.]

Participant Name: _____ Birth Date: ____/____/____

Address: _____

_____

_____

Home Telephone Number: _____ E-mail: _____

Work Telephone Number: _____

Participant Identification Number and/or Social Security Number: _____

By signing this authorization form I authorize The Teamsters Local 170 Health & Welfare Fund or organization(s) described below to use and/or disclose my health information (information that constitutes protected health information as defined in the Privacy Rule of the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996) in the manner described in Section 1. I understand that this authorization is voluntary and I am under no obligation to sign this form. The Teamsters Local 170 Health & Welfare Fund and/or organization(s) described below who I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization.

I understand that the authorized person(s) who receives my protected health information under this authorization may further disclose the protected health information, and it may no longer be protected by federal privacy laws.

I have signed this form voluntarily to document my wishes regarding the use and/or disclosure of the health information described below in Section 1 of this form.

TEAMSTERS LOCAL 170 HEATLH & WELFARE FUND
PARTICIPANT AUTHORIZATION FORM

1. **Description of Health Information I Authorize to be Used or Disclosed.** The following is a specific description of the health information I authorize be used and/or disclosed: (Specify and provide a meaningful description.)

_____

_____

_____

2. **Persons/Organizations Authorized to Use and/or Disclose My Health Information**. I authorize the following person(s) and/or organization(s) (or classes of persons and/or organizations), including the Teamsters Local 170 Health & Welfare Fund, to use and/or disclose the health information described above in Section 1 of this form.

_____

_____

_____

3. **Persons/Organizations Authorized to Receive and/or Use My Health Information**. I authorize the following person(s) and/or organization(s) (or classes of persons and/or organizations) to receive my health information from the person(s) and/or organization(s) described in Section 2 above and to use or disclose such information for the purposes listed below in Section 4 of this form. I understand that if the person(s) and/or organization(s) listed below are not health care providers, health plans or health care clearinghouses subject to federal privacy standards, the health information disclosed pursuant to this authorization may no longer be protected by the federal privacy standards and such person(s) and/or organization(s) may redisclose my health information without obtaining my authorization.

_____

_____

_____

TEAMSTERS LOCAL 170 HEATLH & WELFARE FUND
PARTICIPANT AUTHORIZATION FORM

4. **Description of Each Purpose for the Requested Use and/or Disclosure**. I authorize my health information to be used and/or disclosed for the following specific purposes:

_____

_____

_____

5. **Your Rights with Respect to This Authorization.**

5.1 **Right to Revoke**. I understand that I have the right to revoke this authorization at any time. I also understand that my revocation of this authorization must be in writing. To obtain a copy of an authorization revocation form I may contact the **(Privacy Officer Teamsters Local 170 Health & Welfare Fund PO Box 1046 Worcester, MA 01613 (508) 791-3416)**. I am aware that my revocation will not be effective as to uses and/or disclosures of my health information that the person(s) and/or organization(s) identified in Sections 2 and 3 of this form have already made in reliance upon this authorization.

5.2 **Right to Inspect or Copy the Health Information to be Used or Disclosed.** I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed in accordance with this form. I may arrange to inspect my health information or obtain copies of my health information by contacting the **(Privacy Officer Teamsters Local 170 Health & Welfare Fund PO Box 1046 Worcester, MA 01613 (508) 791-3416).**

5.3 **Right to Receive Copy of This Authorization**. I understand that if I agree to sign this authorization, which I am not required to do, I must be provided with a signed copy of it.

6. **Disclosure of Direct or Indirect Remuneration Received By Any Person or Organization Authorized to Use or Disclose My Health Information**. I understand that the following person(s) and/or organization(s) will be receiving direct or indirect remuneration in connection with the use or disclosure of my health information:

_____

_____

TEAMSTERS LOCAL 170 HEATLH & WELFARE FUND
PARTICIPANT AUTHORIZATION FORM

7. **Expiration of Authorization.** Unless revoked, this authorization is valid from the date of my signature until the date I am no longer insured by The Teamsters Local 170 Health & Welfare Fund or upon the date written below (if any), whichever occurs first. This authorization will automatically terminate upon my death.

☐ This authorization shall terminate on _____/_____/_____.

I, _____ (please print name), have had an opportunity to review and understand the contents of this form. By signing this form, I am confirming that it accurately reflects my wishes.

_____ _____/_____/_____

Participant Signature **Date**

If signed by a personal representative, complete the following:

Name of personal representative: _____

Relationship to participant or nature of authority (e.g., health care power of attorney, guardian, other statutory authorization): _____

Address: _____

_____

_____

Home Telephone Number: _____ E-mail: _____

Work Telephone Number: _____

_____ _____/_____/_____

Signature of Personal Representative **Date**

1/15/03 sg