Sheet Metal Workers Local 73 Welfare Fund
Authorization Form

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I _____ [*name of individual*] hereby authorize the use or disclosure of my health information as described in this authorization.

1. Specific person/organization (*or class of persons*) authorized to provide the information:

   _____

   _____

2. Specific person/organization (*or class of persons*) authorized to receive and use the information

   _____

   _____

3. Specific and meaningful description of the information:

   Please describe the information you wish the Plan to disclose.

   [*E.g., written, electronic and oral information related to eligibility for benefits for the time period commencing on _____ date and continuing through _____ date.*

   E.g., written, electronic and oral information including claims, reports, and other documents related to claims for benefits for an injury or illness commencing on ____ date and continuing through _____ date.

   E.g., written, electronic and oral information relating to payment or lack of payment of benefits to [name of health care provider] for services rendered on _____ date.]

   _____

   _____

4. Purpose of the request:

Please state the purpose of the request below. If you do not wish to state a purpose, please state, "At the request of the individual."

_____

_____

5. Right to Revoke: I understand that I have the right to revoke this authorization at any time by notifying Plan Administrator in writing at Sheet Metal Workers Local 73 Welfare Fund, 4530 Roosevelt Road, Hillside, Illinois 60162. I understand that the revocation is only effective after it is received and logged by Plan Administrator. I understand that any use or disclosure made prior to the revocation under this authorization will not be affected by a revocation.

6. I understand that after this information is disclosed, federal law might not protect it and the recipient might disclose it again.

7. I understand that I am entitled to receive a copy of this authorization.

8. I understand that this authorization will expire on [*insert an expiration date or event, for example, one year*].

_____

_____

9. The Plan will not condition treatment, payment, enrollment or eligibility for health plan benefits on receipt of an authorization.

_____ _____

Signature of Individual Date

If a Personal Representative executes this form, that Representative warrants that he or she has authority to sign the form on the basis of:

_____