LOCAL 371 HIPAA PRIVACY AUTHORIZATION FORM UFCW

AMALGAMATED WELFARE TRUST FUND

As required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and Connecticut law, I understand that my individually identifiable health information may not be verbally disclosed without my authorization except as required or permitted by law.

Patient Date of Birth: _____ **Member ID #:** _____
Phone Number of Patient: _____

I, _____ **(Patient name) authorize Local 371 AWTF to use and disclose protected health information described below to the following individual(s)**

Name: _____
Phone Number: _____ **Relation to patient:** _____

Name: _____
Phone Number: _____ **Relation to patient:** _____

This authorization for release of information covers the period of health care

A. ☐ From _____ **to** _____.
B. ☐ For all past, present and future periods.

☐ I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse.

Or

☐ I authorize the release of my complete health record with the exception of the following information:

- **☐ Mental health records**
- **☐ Communicable diseases (including HIV and AIDS)**
- **☐ Alcohol/drug abuse treatment**
- **☐ Other (Please specify)** _____

I understand that I have the right to revoke this authorization in writing at any time except (i) to the extent information has already been shared based on this authorization or (ii) this authorization was obtained as a condition of obtaining insurance coverage. I understand if I revoke this authorization I must do so in writing and present my written revocation to the appropriate designated party of the Local 371 Amalgamated Welfare Trust Fund.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form in order to assure treatment, payment, enrollment in a health plan or eligibility for benefits.

Any facsimile, copy, photocopy or electronic copy of this authorization shall be effective to authorize the disclosure of the records herein.

_____ _____
Print Name of Patient or Legal Representative **Date of Signature**

_____ _____
Signature of Patient or Legal Representative **If signed by Legal Representative, Relationship to Patient**

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