Your Future — Our Focus

Chicago Regional Council of Carpenters Welfare Fund

12 East Erie Street
Chicago, IL 60611
312-787-9455, Phone Option #3

Instructions for Completing an Authorization for Release of Protected Health Information

1. **Complete the "Authorization for Release of Protected Health Information" form in its entirety**. Print clearly in blue or black ink and answer all questions. If the form is not legible, if a question is left unanswered or if the form is not signed it will be returned to you for completion. An Authorization for Release of Protected Health Information Form must contain an expiration date, a signature and date to be valid. If you are submitting the "Authorization for Release of Protected Health Information" form other than in person, for identification purposes, you **must** also submit a copy of a government issued identification card. Acceptable forms of ID include a driver's license, state ID, passport or resident alien identification card. If you are unsure of what forms of ID are acceptable, please contact the Fund office at 312-787-9455 and press phone option 3 to speak with a Participant Services representative Monday through Friday from 8:00 AM to 4:30 PM.

2. **Submit the fully completed and signed "Authorization for Release of Protected Health Information" form to**:

Scan & Email:	activeenrollment@crccbenefits.org
Fax:	Chicago Regional Council of Carpenters Welfare Fund Attn: HIPPA Privacy Officer Fax Number: 312-951-1515
Mail:	Chicago Regional Council of Carpenters Welfare Fund Attn: Participant Services Department 12 East Erie Street Chicago, IL 60611

Important Note:

- ✓ Only the attached Authorization for Release of Protected Health Information form will be accepted by the Chicago Regional Council of Carpenters Welfare Fund. No other authorization for release of protected health information forms will be accepted.
- ✓ The Plan will automatically recognize any person who holds a legal Healthcare Power of Attorney for an individual as that individual's personal representative.
- ✓ A Power of Attorney will not be accepted unless it specifically addresses decisions related to healthcare.

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CHICAGO REGIONAL COUNCIL OF CARPENTERS WELFARE FUND

Authorization for Release of Protected Health 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.

   Examples:
   a. *Written, electronic and oral information related to eligibility for benefits for the time period commending on _____ [date] and continuing through _____ [date].*
   b. *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].*
   c. *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. Please state the specific purpose of the request below.

   _____
   _____

5. Right to Revoke: I understand that I have the right to revoke this authorization at any time by notifying the Privacy Official in writing at:

   Privacy Official
   Chicago Regional Council of Carpenters Welfare Fund
   12 East Erie Street
   Chicago, Illinois 60611

6. I understand that the revocation is only effective after it is received and logged by Privacy Official. I understand that any use or disclosure made prior to the revocation under this authorization will not be affected by a revocation.
7. I understand that after this information is disclosed, federal law might not protect it and the recipient might disclose it again.
8. I understand that I am entitled to receive a copy of this authorization.
9. I understand that this authorization will expire on _____ [*insert an expiration date or event, for example, today's date].*
10. *The Plan will not condition treatment, payment, enrollment or eligibility for health plan benefits on receipt of an authorization.*

_____ _____ _____

Signature of Individual ID# or SS# 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: (Please attach a copy of the signed document authorizing you to act as a Personal Representative.)