New York State Teamsters Council Health and Hospital Fund

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AUTHORIZATION FOR THE USE AND DISCLOSURE OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION/PROTECTED HEALTH INFORMATION

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that the information I authorize a person or entity to receive may be re-disclosed and no longer protected by federal privacy regulations.

1. **Specific description of information that may be used/disclosed:**
   ____
   ____
   ____

2. **The information will be used/disclosed for the following purpose(s):**
   ____
   ____
   ____

3. **Persons/organizations authorized to use or disclose the information:**
   ____
   ____
   ____

4. **Persons/organizations authorized to receive the information:**
   ____
   ____
   ____

5. **The person/organization authorized to use/disclose the information will receive compensation for doing so. Yes_____ No ______**

6. **I understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment, payment for or coverage of services, or ability to obtain treatment, except as provided under numbers 7 and 8 on this form.**

7. **If the purpose of this authorization is for the Fund to determine eligibility before enrollment, the requested use or disclosure is not for psychotherapy notes, and I refuse to sign this authorization, the Fund reserves the right to deny enrollment or eligibility for benefits.**

8. If the purpose of this authorization is to disclose health information to another party based on health care that is provided solely to obtain such information, and I refuse to sign this authorization, the Fund reserves the right to deny that health care.

9. I understand that I may inspect or copy the information used or disclosed.

10. I understand that I may revoke this authorization at any time by notifying the Fund in writing, except to the extent that:

(a) action has been taken in reliance on this authorization; or

(b) if this authorization is obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.

11. I understand that I have a right to request and receive a Notice of Privacy Practices from the Fund.

12. This authorization expires on/upon____
[insert applicable date or event]

____ ______________________
Signature of Member **Date**

____
Printed Name of Member

____
Social Security Number

____
Relationship of Authorized Person/Organization