Health Insurance Authorization for Release of Health Information

Greater St. Louis Construction Laborers' Welfare Fund
2357 59th Street St. Louis, MO 63110 www.stllaborers.com

I understand that the Greater St. Louis Construction Laborers' Welfare Fund Benefit Office, pursuant to new privacy laws, may not generally disclose my health information without my written authorization to my family members or other individuals that I may want to have access to my health information. For this reason, I authorize Greater St. Louis Construction Laborers Welfare Fund to discuss and disclose my health information that is maintained by the Fund to the person(s) that I have named below.

I understand that I have the right to limit the information that the Fund releases under this authorization. For example, I may limit my Authorized Representative's access to information about a particular health care provider or a particular diagnosis/disease. Any such limitations must be described below in writing. I understand that by leaving this section blank, I am creating no limitations on disclosure.

Member Name:	Medical Member ID:
Authorized Representative Name #1:	Relationship to You:
Authorized Representative Name #2:	Relationship to You:
Do you want your representative(s) to have limits? ☐ Yes ☐ No If yes, be sure to list the limits: ***I authorize the Construction Laborers' Welfare Fund to share my information with the Pension Fund related to my retirement?*** ☐***Yes*** ☐***No*** ***I authorize the Construction Laborers' Benefit Office to share my contribution/eligibility information with my Union Hall?*** ☐***Yes*** ☐***No***	
Signature:	Date:

Spouse Name:	Medical Member ID:
Authorized Representative Name #1:	Relationship to You:
Authorized Representative Name #2:	Relationship to You:
Do you want your representative(s) to have limits? ☐ Yes ☐ No If yes, be sure to list the limits:	
Signature:	Date:

This authorization to release information to my Authorized Representative will automatically expire upon a lapse of my enrollment in the plan for a period of two consecutive years.

1. You may revoke this Authorization at any time. However, any revocation will not apply to the extent that we have already taken action in reliance upon your Authorization. Your request for revocation must be in writing. We will provide you with a revocation form at your request.
2. We may not condition the provision of treatment, payment, enrollment in a health plan, or eligibility for benefits upon your signing this Authorization.
3. Information used or disclosed pursuant to this Authorization may be subject to redisclosure by the recipient and may no longer be protected by Federal health information privacy laws.
4. You are entitled to a signed copy of this Authorization.

I have had full opportunity to read and consider the content of this Authorization. I confirm that this authorization is at my request. I understand that, by signing this form, I am confirming my authorization that the health plan may use and/or disclose my personal health information to the person(s) named in Section B.

Be sure to return this form if you would like to authorize an individual(s).