REDWOOD EMPIRE ELECTRICAL WORKERS HEALTH AND WELFARE PLAN
HIPAA AUTHORIZATION FOR RELEASE OF INFORMATION

Participant Name: _____ Birth Date: _____/_____/____
Address: _____
_____
Daytime Telephone Number: _____

By signing this authorization form, I hereby authorize the Redwood Empire Electrical Workers Health and Welfare Plan ("Plan") to use and/or disclose my individually identifiable health information in the manner described below. I understand that I may obtain a copy of this authorization upon request.

1. Description of the Health Information I authorize to be Used or Disclosed: (ex: information relating to my claim or eligibility for benefits)

_____

_____

I understand that the Plan requires my more specific authorization to disclose certain health information about me. By setting forth my initials, I hereby authorize the Plan to disclose the information below for the purpose described in paragraph 2.

Chemical dependency _____ HIV/AIDS _____ Genetic Information ____ Mental Health Information _____

2. Purpose of the Requested Use or Disclosure: (ex: to assist in the resolution of my claim or eligibility status):

_____

_____

3. Person(s)/Organization(s)/Class(es) of Person(s) Authorized to Receive and/or Use My Health Information (include name, address and phone number if applicable): (ex: my advocate)

_____

I understand that the health information disclosed pursuant to this authorization may be re-disclosed by the receiving party and may thereafter no longer be protected by the federal privacy standards.

4. Your Rights with Respect to This Authorization. I understand that I have the right to revoke this authorization in writing at any time. Written revocation must be sent to the Plan at 2525 Cleveland Avenue, Suite C, Santa Rosa, CA 95403. I understand that any revocation sent to the Plan is only effective after it is received and logged by the Plan. I understand that any revocation will not be effective as to uses and/or disclosures of my health information that the disclosing entity made prior to receiving such revocation in reliance upon this authorization. I understand that the Plan will not condition treatment, payment, enrollment, or eligibility for health benefits under the health care components of the Plan on the receipt of an authorization.

5. Expiration of Authorization. I understand that this authorization will expire on: (1) the date I indicate here, or (2) the event indicated here (ex: the resolution of my claims) or (3) if neither is indicated, the last day of my enrollment in the Plan program to which this authorization relates. _____
_____

I hereby acknowledge that I have reviewed and understand the contents of this authorization. By signing this form, I am confirming that it accurately reflects my wishes.

_____ _____/_____/_____
Participant Signature (or Personal Representative) Date

If signed by a personal representative, complete the following:

Name, address and phone number of personal representative: _____
_____
Relationship to participant or nature of authority (e.g., health care power of attorney, guardian/parent, other statutory authorization): _____

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Instructions for Completing the Redwood Empire Electrical Workers Health and Welfare Plan HIPAA Authorization for Release of Information

On April 14, 2004, a new federal regulation governing the privacy of health information became applicable to the Redwood Empire Electrical Workers Health and Welfare Plan ("Plan"). This regulation requires the Plan to implement safeguards to protect the confidentiality of the health information it maintains on behalf of its participants. These safeguards require the Plan to restrict how it uses and discloses participant health information. Consequently, the Plan may only disclose participant health information pursuant to an authorization or a provision of the regulation that permits such disclosure.

In keeping with its commitment to protect the confidentiality of your health information, the Plan has prepared the attached authorization form and the instructions below for your use if you are authorizing the Plan to provide your Plan records to someone outside the Plan, for ex., your lawyer. If you have any questions regarding the form or instructions, please contact the Plan at **(707) 526-1996**. Please:

A) Print your name, birth date, address and telephone number in the space provided.

B) In the paragraph marked (1), describe the information you wish to be disclosed or made available for use. For example, you may state "Information relating to my claim submitted on month/date/year" if you are completing the authorization for claims purposes. If you would like information disclosed about you concerning chemical dependency, HIV/AIDS, genetic information, or mental health, you must write your initials in the applicable space(s) provided.

C) In the paragraph marked (2), describe the purpose of the requested use or disclosure. For example, if you are completing the authorization for claims purposes, you may state "to assist in the resolution of my claim". If you have initiated this authorization and do not wish to provide a statement of the purpose of the requested use or disclosure, you may write "At my request" in the space provided.

D) In the paragraph marked (3), provide the name of the person, organization or class of persons authorized to **receive and use** the information to be disclosed. For instance, you may authorize a particular individual to receive the information, for example, your advocate.

E) In the paragraph marked (4), the form explains your rights with regard to the authorization.

F) In the paragraph marked (5), provide the expiration date or event for the authorization. If you do not specify a date, the authorization will automatically expire the last day of your enrollment in the program to which this authorization relates.

G) In the spaces provided, sign your name and enter today's date.

If the authorization form is being completed by a your personal representative, the personal representative should sign and date the form in the spaces provided. In addition, the personal representative must specify the relationship which authorizes him or her to act on your behalf. The Plan may require submission of applicable legal documentation if an individual bases his or her status on a power of attorney, conservatorship, guardianship, a will or other testamentary trust, or any other status governed under applicable law.

You may mail this form to the Redwood Empire Electrical Workers Trust Fund, 2525 Cleveland Avenue, Suite C, Santa Rosa, CA 95403 or return it by facsimile to (707) 526-7248.