

Instructions for Completing the *Individual Authorization to Release Protected Health Information (PHI) Form*

- Please read the entire form prior to completing.
- This form must be used to authorize the release of PHI to a named individual(s).
- You have more than one choice regarding the type of disclosures you are authorizing. They are:

GENERAL AUTHORIZATION with No Time Limitations. Authorizes MCTWF to release all PHI to the individual(s) you specify without time limitations. If the person you are authorizing is not a participant or covered dependent of MCTWF, please supply their address, telephone number, social security number and date of birth.

The following Sections must be filled out *entirely* for a general disclosure:

- Section #1
- Section #2
- Section #7 (only if you are a personal representative)

GENERAL AUTHORIZATION with Time Limitations. Authorizes MCTWF to release all PHI to the individual(s) you specify with time limitations. If the person you are authorizing is not a participant or covered dependent of MCTWF, please supply their address, telephone number, social security number and date of birth.

The following Sections must be filled out *entirely* for a general disclosure with time restrictions.

- Section #1
- Section #2
- Section #6
- Section #7 (only if you are a personal representative)

ALL OTHERS. Authorizes MCTWF to release PHI based on a specific condition or claim to the individual(s) you specify for a specific time period.

The following Sections must be filled out *entirely* for a specific disclosure with time limitations.

- Section #1
- Section #3
- Section #4
- Section #5
- Section #6
- Section #7 (only if you are a personal representative)

- If you have any questions regarding the completion of this form, please contact the MCTWF's Member Services Call Center at 313-964-2400.

MICHIGAN CONFERENCE OF TEAMSTERS WELFARE FUND
2700 Trumbull Detroit, MI 48216



Michigan Conference of Teamsters Welfare Fund Individual Authorization to Release Protected Health Information

This form can not be used for the authorization to release psychotherapy notes.

Section #1: Individual Information

I certify that I am (check all that apply):

- A participant (employee/retiree)
- A participant's spouse or surviving spouse
- A non-spousal dependent of a participant
- A personal representative*

Name of Participant: _____
(print name)

Participant's Contract Number: _____ - _____ - _____ Participant's Birth Date _____ / _____ / _____
MM / DD / YR

You can contact me at:

Home Telephone Number: _____ E-mail: _____

Work Telephone Number: _____

I am authorizing release of information on (check only one):

- Myself (print name) _____
- My dependent minor child (print name) _____
- A covered individual for whom I am the personal representative* (print name) _____

**Note: If you are a personal representative of the individual and you are completing this form on behalf of the individual, you must complete the personal representative area found in Section #7. Personal representative means a person with legal authority (under State or applicable law) to act on behalf of the individual in making health care decisions.*

This form authorizes the Michigan Conference of Teamsters Welfare Fund (MCTWF) to disclose your protected health information (as defined in the Privacy Rule of the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to individuals you specify. You do not have to authorize disclosure to others, except that MCTWF may require you to authorize disclosure:

- for enrollment in the health plan(s) of MCTWF or for eligibility for benefits, if the authorization will allow MCTWF to obtain the information it needs to make an eligibility, enrollment, underwriting or risk rating determination, and
- before paying a claim, if this authorization will allow MCTWF to obtain information it needs to make a claim payment determination.

The form includes a General Authorization (Section 2) which authorizes MCTWF to disclose any or all of the protected health information maintained by MCTWF, to the individual you specify with respect to the period you are covered by MCTWF.

You also may authorize narrower disclosures by specifying particular information to be disclosed for particular purposes by filling out Sections 3-6, below.

I understand that:

- I have the right to revoke this authorization at any time, but that I must do so in writing by using a Revocation of Authorization form available from the Privacy Officer at the Michigan Conference of Teamsters Welfare Fund, 2700 Trumbull Avenue, Detroit, MI 48216 or (313) 964-2400. I am aware that my revocation will not change any use and/or disclosure of the health information that has already occurred because I signed this authorization.



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- I can inspect or copy the health information I have authorized to be used or disclosed by contacting the Privacy Officer at the Michigan Conference of Teamsters Welfare Fund, 2700 Trumbull Avenue, Detroit, MI 48216 or (313) 964-2400.
- I am entitled to a copy of my signed authorization.
- Once my information has been disclosed as permitted under this authorization, I understand that if the person(s) and/or organization(s) listed in this section are not health care providers, health plans or health care clearinghouses subject to federal privacy standards, the health information disclosed pursuant to this authorization may no longer be protected by the federal privacy standards and such person(s) and/or organization(s) may re-disclose the health information without obtaining my authorization.

Section #2: General Authorization

At my request, I, _____, authorize the Michigan Conference of Teamsters Welfare Fund to use or disclose any or all of my protected health information maintained by the Michigan Conference of Teamsters Welfare Fund to the below listed individual with respect to the period I am covered by the Michigan Conference of Teamsters Welfare Fund, or sooner as stated in Section #6 (Expiration of Authorization).

_____	_____	_____
Name	Address	City, State Zip
_____	_____	_____ / _____ / _____
Telephone Number	Social Security Number	Date of Birth

Information regarding behavioral and mental health services, substance use disorder treatments, and communicable diseases such as sexually transmitted diseases and human immunodeficiency virus (HIV infection, Acquired Immune Deficiency Syndrome or AIDS related complex) may be shared if I initial here _____. If you authorize the release of substance use disorder treatment information, the recipient cannot re-disclose this information without my permission unless permitted under federal or state law.

I have reviewed this form and understand its contents. I have signed this form voluntarily to document my wishes about the use and/or disclosure of my health information.

_____	_____ / _____ / _____
Signature	Date of Signature
Address: _____	MM / DD / YR

Section #3: Information to Be Used or Disclosed (Complete if General Authorization is not requested under Section #2)

Information regarding behavioral and mental health services, substance use disorder treatments, and communicable diseases such as sexually transmitted diseases and human immunodeficiency virus (HIV infection, Acquired Immune Deficiency Syndrome or AIDS related complex) may be shared if I initial here _____. If you authorize the release of substance use disorder treatment information, the recipient cannot re-disclose this information without my permission unless permitted under federal or state law.

I authorize MCTWF to use or disclose the following specific health information (Specify and provide a meaningful description):



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Section #4: Who May Receive and/or Use the Health Information (Complete if General Authorization is not requested under Section #2)

I authorize the following person(s) and/or organization(s) (or classes of persons and/or organizations) to receive the health information described in Section #3 and to use or disclose such information for the purposes listed in Section #5 of this form.

Section #5: How the Information May be Used or Disclosed (Complete if General Authorization is not requested under Section #2)

I authorize the health information to be used and/or disclosed for the following specific purposes:

Section #6: Expiration of Authorization

This authorization will expire (choose and complete one):

On ____/____/____. (FUTURE DATES ONLY)
MM / DD / YR

If the following event(s) related to health care services or the purpose(s) identified in Section #5 occur:

I, _____ (print name), have reviewed this form and understand its contents. I have signed this form voluntarily to document my wishes about the use and/or disclosure of the health information described in Section #3.

Signature _____ MM / DD / YR

Address: _____

Section #7: Personal Representative

If signed by a personal representative, complete the following:

Name of personal representative: _____
(print name)

Name of individual you are representing: _____
(print name)

Relationship to individual or nature of authority (e.g., health care power of attorney, guardian, other statutory authorization):



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Note: You must provide valid and current proof of your legal relationship as a personal representative.

Personal Representative Contact Information

Address: _____

Home Telephone Number: _____

E-mail: _____

Work Telephone Number: _____

Signature of Personal Representative

____/____/____ Date of Signature
MM / DD / YR

Section #8: Submission Instructions

Submit Form to: Privacy Officer
Michigan Conference of Teamsters Welfare Fund
2700 Trumbull Avenue
Detroit, MI 48216