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

This form must be used by the Authorizing Individual for the release of PHI to a named person or entity. This form cannot be used to authorize release of psychotherapy notes.

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 the person(s) and/or organization(s) 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 the authorization will allow MCTWF to obtain information it needs to make a claim payment determination.

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

Section #1: Authorizing Individual Information

Name _____ Birth Date _____/_____/_____
Please Print MM / DD / YR

Contract Number _____ or Social Security Number _____
(Found on ID card)

Address _____

City _____ State _____ ZIP Code _____

Telephone Number _____ E-mail _____

Section #2: Protected Health Information to be Shared

I am authorizing the Michigan Conference of Teamsters Welfare Fund to release Protected Health Information (PHI) described below (check only one):

☐ Any and all PHI requested

☐ Only limited information (such as for specific treatments, dates of service, or billing details): *(please describe)*

_____

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 I 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 am authorizing the Michigan Conference of Teamsters Welfare Fund to release Protected Health Information (PHI) described above for the following purpose (check only one):

☐ To give out the information as shown on this form

☐ Only for the following purpose (such as for litigation or specific inquiry)

*(please describe)*_____

Section #3: Person or Entity Authorized to Receive Protected Health Information

I authorize the following person(s) and/or entity (or classes of persons and/or entities) to receive the PHI described in Section #2.

Person or Entity Name _____ Telephone Number _____

Address _____

City _____ State _____ ZIP Code _____

Section #4: Expiration of Authorization

This authorization will expire:

☐ Ten years from the date of my signature

☐ On _____/_____/_____ (FUTURE DATES ONLY)
MM / DD / YR

☐ At the conclusion of the following event(s) related to health care services or the purpose(s) identified in Section #2:
*(please describe)*_____

Note: If I fail to select an expiration option above, this authorization will expire one year from the date of my signature.

Section #5: Authorization and Signature

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 by calling (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.
- 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) is not legally required to obey privacy laws, the information may no longer be protected and may be re-disclosed without my authorization.

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

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

☐ I am the personal representative for the member.*

**Note: 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. Please complete Section #6.*

Section #6: 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):

_____*Note: If other than natural parent of a minor child, valid and current proof of legal relationship as personal representative must be provided.*

Personal Representative Contact Information

Address _____ Telephone Number _____

_____ E-mail _____

_____ Date of Signature _____/_____/_____
Signature of Personal Representative MM / DD / YR

Privacy Officer
Submit Form to: ***Michigan Conference of Teamsters Welfare Fund***
2700 Trumbull Avenue
Detroit, MI 48216
Or Fax to: ***313-496-2943***