Central Laborers' Welfare Funds

P.O. Box 1267 • Jacksonville, Illinois 62651 • Phone 217/479-3600 • Fax 217/243-8619

Since the inception of the Federal HIPAA Privacy regulations, Central Laborers' Welfare Fund ("Fund") is required to limit the type of information that may be released to any individual related to Health & Welfare Benefits. The Fund understands that HIPAA imposed limitations may cause difficulties for participants and their families. For example, because of HIPAA, the Fund is prohibited to share information in the following situations:

- With a spouse regarding a Participant's claims;
- With a parent regarding an 18-year-old or older dependent's claims;
- With a parent, guardian or other individual not on the benefit plan regarding a dependent who was underage; or
- With a Local Union representative attempting to assist participants with eligibility or Welfare Fund Benefits.

To minimize the difficulties described above, the Fund is providing the attached HIPAA Authorization to Release Protected Health Information ("Authorization"). The Authorization, once signed and returned to the Fund, will permit the Fund to discuss certain information with the individual(s) that you designate. Please understand, you are not obligated to designate anyone. Again, you are offered this option to minimize the type of difficulties discussed above.

By completing and submitting the Authorization form, you or your authorized representative are authorizing the Fund to discuss or share certain protected health information. The form is simple to complete and only requires you to do the following (all areas to complete have been highlighted in gray):

1. Read and review the form.
2. Confirm the name of the person authorizing disclosure of information is correct as stated in Section 1, Part 1,
3. Complete Section 1, Part 1 by writing in the name of a person or persons you are authorizing to receive certain HIPAA protected information. For example – your Spouse, your Parent or other person.
4. Complete Section 1, Part 2, by writing in the name of your Local Union or your Employer (example – LL# 477 or ABC Construction) you are authorizing to receive certain HIPAA protected information.
5. Check or describe the type of information you are giving the Fund permission to disclose to person(s) designated in Section 1, Part I and Section 1, Part 2.
6. Complete Section 2.
7. Complete Section 3
8. Complete Section 4, then sign and date the Authorization.
9. Return the form in the envelope included.

Please be aware that the Fund will not disclose your protected health information with anyone other than the individual(s) identified on the form or as permitted under the HIPAA Privacy regulations.

You always have the right to revoke your authorization, should you no longer want the Fund to disclosure your protected health information with the designated individual(s). To revoke your authorization, please complete the Revocation Form that can be downloaded from www.central-laborers.com or you may request to receive a copy of the form by calling the Fund Office. Please be aware, a request to revoke your authorization will be effective on the date it is received in the Fund Office.

If you have questions, concerns or need assistance completing the form, do not hesitate to contact the Fund Office at 1-800-252-6571.

Sincerely,
Central Laborers' Welfare Fund

CENTRAL LABORERS' WELFARE FUND

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Federal law prohibits insurers from sharing your health information without permission except in certain situations. This form authorizes the Central Laborers' Welfare Fund ("Fund") to share protected health information with the person(s) designated below.

Section 1: Recipient of Information and Description of Information to be Released

I, _____(first & last name), Policy ID: _____(ID# from insurance card), give permission for the **Fund** to share my protected health information as designated below:

Part 1. Share with _____, the following Information:

NAME OF THE PERSON YOU WANT TO RECEIVE INFORMATION
(EXAMPLE – YOUR SPOUSE'S FULL NAME OR A DEPENDENT'S FULL NAME)

(Check Appropriate Box – More than One Box may be selected)

☐ All **My Eligibility Information** (including, but not limited to, information regarding hours worked, dates of eligibility, COBRA eligibility and self-payments).

☐ All **My Medical Claim Information** that is received or maintained by the Fund which will include (i) information regarding all my health/medical conditions (including, but not limited to, chronic diseases, behavioral health conditions, substance abuse conditions, communicable diseases (including HIV/AIDS), and genetic information, but excluding psychotherapy notes), and (ii) information regarding the payment of claims, medical diagnosis, dates of service, case management, appeals and any other claims information or records related to my health/medical conditions received by the Fund.

☐ **Other (Please Specify)**_____

_____

Part 2. Share with representatives of _____, the following information:

LOCAL UNION OR EMPLOYER TO RECEIVE INFORMATION
(EXAMPLE – LL #477 OR WICKER CONSTRUCTION)

(Check Appropriate Box – More than One Box may be selected)

☐ All **My Eligibility Information** (including, but not limited to, information regarding hours worked, dates of eligibility, COBRA eligibility and self-payments).

☐ All **My Medical Claim Information** that is received or maintained by the Fund which will include (i) information regarding all my health/medical conditions (including, but not limited to, chronic diseases, behavioral health conditions, substance abuse conditions, communicable diseases (including HIV/AIDS), and genetic information, but excluding psychotherapy notes), and (ii) information regarding the payment of claims, medical diagnosis, dates of service, case management, appeals and any other claims information or records related to my health/medical conditions received by the Fund.

☐ **Other (Please Specify)**_____

_____

Section 2: Purpose for Disclosure

Check one: ☐ At my request. ☐ Other_____

Section 3: Expiration/Revocation

This authorization will expire (check one box only):

☐ **The later of when I revoke this authorization or when I lose eligibility with the Fund.*****

OR

☐ **Upon the following date:**_____/_____/_____

For the authorization to be effective, one of the above boxes must be checked/completed.

***If you check this box, you agree that this authorization will remain in effect until termination of your enrollment/eligibility with the Fund or you revoke your authorization by completing and submitting a REVOCATION FORM. Additionally, unless you submit a written REVOCATION FORM, you further agree that this authorization will remain in effect during all periods of your eligibility (including periods of eligibility between periods of ineligibility). A REVOCATION FORM can be found on the Fund's website www.central-laborers.com or by requesting one from the Fund Office at 1-800-252-6571. Your request to revoke this authorization will be effective the day it is received by the Fund Office. Note, any use or disclosure made prior to the revocation of this authorization will not be affected by the revocation.

Section 4: Approval and Signature

I understand that this authorization to release protected health information is voluntary and is not a condition of enrollment in the Fund, eligibility for benefits, or payment of claims. I also understand that if the person(s) or organization(s) I authorize to receive the information described above is not subject to federal health information privacy laws, they may further release the protected health information and it may no longer be protected by federal privacy laws.

By signing below, I authorize the release of my protected health information as described above.

Signature	
Print Name	Date

If signed by a person other than the individual identified on this form, complete the following:

1) Individual is: ☐ a minor ☐ legally incompetent or incapacitated ☐ deceased
2) Legal Authority: ☐ parent * ☐ legal guardian* ☐ Power of Attorney* ☐ executor of deceased*

*By signing the above, I agree to produce any documents required to confirm my legal authority as noted above before this authorization can be effective.

Return the Completed Form to:

Central Laborers' Welfare Fund
PO Box 1267
Jacksonville, IL 62651
Fax: 217-243-8619
Email: claims@central-laborers.com