I.B.E.W. 292 HEALTH CARE PLAN

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION BY THE HEALTH PLAN

You MUST complete all the information in the Form for your Authorization to be valid.

MAIL, FAX OR EMAIL THE COMPLETE FORM TO THE IBEW 292 BENEFITS OFFICE
6900 Wedgwood Road North, Suite 425, Maple Grove, MN 55311
Phone (763) 493-8830 • (800) 368-9045 • Fax (763) 416-6196 • enrollment@ibew292benefits.org

I authorize the Plan to use or disclosure of my health Protected Health Information ("PHI") as described in this authorization.

(1) The Plan can release PHI to: The Plan, it's agents or subcontractors ("The Business Associates) is authorized to release the PHI described below to the follow person, class of persons, or organizations:

☐ My spouse (Name)_____ ☐ My Employer
☐ My Parents (Names)_____ ☐ My Union's Staff
☐ Other (Print Name or Position)_____
Note: If you want to authorize the Plan to release information only to a specific person working for your employer or Union, check "Other: and print the person's name.

(2) The information that may be used or released is:

☐ Any and all:

☐ Medical information held by the Plan from the following doctor, clinic or hospital:

_____

☐ Information held by the Plan concerning my eligibility, claims decisions and payments.

☐ Other. Please specify below:

_____

(3) **Right to revoke:** I understand that I have the right to revoke this authorization at any time by notifying the Plan's Contact Person in writing at the above address. I understand that the revocation is only effective after it is received and logged by the Plan. I understand that any use or disclosure made prior to the revocation under this authorization will not be affected by a revocation.

(4) **Re-Release of Information:** I understand that after this information is released, federal law might not protect it and the recipient might re-release it. I also understand and agree to hold the plan and any of its agents and subcontractors harmless if the information is re-released.

(5) THIS AUTHORIZATION WILL EXPIRE DECEMBER 31, 2024 UNLESS YOU GIVE AN EARLIER DATE OR TERMINATION EVENT BELOW.
Other: _____

Your Signature:_____ Date:_____

Print Your Name: _____

Member Name:_____ SS# of Member:_____

If more authorizations for additional family members over the age of 18 are needed, please make copies of this form.

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