Southern California Lumber Industry Welfare Fund
Authorization for the Disclosure of Protected Health Information
1200 Wilshire Blvd., Fifth Floor, Los Angeles, CA 90017-1906
Privacy Official (562) 463-5080, Fax (562) 463-5894

As required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) the Administrative Office may not use or disclose your health information except as provided in our Notice of Privacy Practices without your authorization. Your signature on this form indicates that you are giving permission for the uses and disclosures of Protected Health Information (PHI) described herein. You may revoke this authorization at any time by signing and dating the revocation section on your copy of this form and returning it to this office.

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

I, ____ (print name) hereby authorize the Administrative Office Staff to make the following disclosures of my health information.

HEALTH INFORMATION TO BE DISCLOSED "AT THE REQUEST OF THE INDIVIDUAL"

Health information to be disclosed: ____

____

(A **specific and meaningful** description of the information to be disclosed is required)

DISCLOSED TO

I further authorize the following person(s) or entity to receive these disclosures of my health information:

Name: ______________________________ Title/Relationship: ______________________

Address: ____

____

Phone: ______________________________ Fax: ______________________________

AUTHORIZATION EXPIRATION

I understand that this authorization will automatically expire (enter date or event):

☐ Date: ______________________

☐ Event: ____

SIGNATURE

I understand that information disclosed pursuant to this authorization may potentially be re-disclosed by the recipient to additional parties and no longer protected by the HIPAA Privacy Rule.

I understand that I am under no obligation to sign this authorization. I further understand that the Fund may not condition my ability to obtain treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization.

I understand that I have a right to inspect and to obtain a copy of any information disclosed pursuant to this authorization. This authorization will be valid only when all sections are completed.

Signed: ______________________________________ Date: ______________________

Social Security Number: ______________________________

If not signed by the participant, please indicate relationship or describe the authority to represent the participant: ______________________

____

Print Member Name: ______________________________ Member SS#: ______________________

REVOCATION

I understand that I may revoke this authorization at any time by signing the revocation section of my copy of this form and returning it to the Administrative Office subject to the exceptions in the Fund's Notice of Privacy Practices. I further understand that any such revocation does not apply to the extent that persons authorized to use or disclose my health information have already acted in reliance on this authorization.

☐ I hereby revoke this authorization. (NOTE: This section is to be signed only to revoke this Authorization.)

Signature: ______________________________________ Date: ______________________

A COPY OF THIS AUTHORIZATION IS TO BE GIVEN TO THE PARTICIPANT