Dependent HIPAA Authorization Form

Return this completed form to:

Fox Valley Laborers Health and Welfare Fund
2371 Bowes Road, Suite 500
Elgin, IL 60123-5523

Email: customerservice@fvlab.com **Fax:** (847) 742-4430 **Phone:** (847) 742-0900 **www.fvlab.com**

Authorization to Disclose Protected Health Information

My protected health information is individually identifiable health information, including demographic information collected from me or created or received by a health care provider, a health plan, my employer, or a health care clearinghouse, and relates to: (i) my past, present, or future physical or mental health condition; (ii) the health care provided to me; or (iii) the past, present or future payment for health care provided to me.

HIPAA Authorization

The Dependent must complete both sides of this form to authorize the disclosure of protected health information to others.

Primary Account Holder Information *(please PRINT clearly)*

Last Name _____ First Name _____ M.I. _____

Street Address _____ City _____ State _____ Zip Code _____

Email address (required) _____ ( ) Best contact phone number _____ SSN or FVL ID Number _____

Release of Protected Health Information

1. **I authorize Fox Valley Laborers Health and Welfare Fund to release the following information:** *(Circle all that apply)*

Claims Status Eligibility Eligibility Cards Hours Worked

2. **If my records contain information about the following, I authorize Fox Valley H&W Fund to release :** *(Circle all that apply)*

Drugs Alcohol Mental Health Sexually Transmitted Diseases HIV/AIDS

The CIRCLED information above may be released to the following individuals:

Name *(please PRINT clearly)* _____ Relationship _____ Date of Birth _____

Name *(please PRINT clearly)* _____ Relationship _____ Date of Birth _____

Please complete the information on the back of this page

Authorization of HIPAA Disclosure *(to be signed by the Dependent or Personal Representative*)*

This authorization will remain in effect unless effectively revoked in writing by the Dependent for the duration of the stated expiration requirement (which may vary from 24-48 months) based on the Dependent's state of residency.

I may revoke or cancel this authorization at any time by notifying the HIPAA Privacy Official at the Fox Valley Laborers Health and Welfare Fund in **writing.** I understand I must send that notification by email, fax or mail.

I understand that by granting this authorization, the person who obtains this information may disclose this information to other individuals with or without my consent and, in so doing, the information is no longer protected under Federal or State HIPAA legal privacy requirements.

I understand that my authorizing the disclosure and use of this information is not a condition of enrollment in this health plan, eligibility for benefits or payment of claims.

Further, I understand that I do not have to sign this Authorization, that my treatment or payment for services will not be denied if I do not sign this Authorization, and that I can inspect and obtain a copy of the Protected Health Information to be used or disclosed.

I hereby authorize Fox Valley Laborers Health and Welfare Fund to release the Protected Health Information as specified on the previous page.

Signature of Individual or Personal Representative* Who May Request Disclosure

_____ _____
Dependent or Personal Representative Signature — Date

_____ _____
Dependent or Personal Representative Name *(please PRINT clearly)* — Date of Birth (MM/DD/YYYY)

_____ ( ) _____ _____
Email address (required) — Best contact phone number — SSN or FVL ID number

***Note**: If the person signing above is a Personal Representative of the Dependent, check here ____*
and attach copy of the document granting authority of disclosure to the Personal Representative.

If, at any time, this authorization form needs to be changed, please contact Fox Valley Laborers Health and Welfare Fund at (847) 742-0900.

FOX VALLEY & VICINITY LABORERS

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