

South Bay Hotel Employees, Restaurant Employees Trust Funds

2815 Second Ave., Suite 300 • P. O. Box 34203 • Seattle, Washington 98124
Phone (206) 441-7574 or (800) 544-5085 • Fax (206) 441-9110

Administered by
Welfare and Pension Administration Service, Inc.

AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

Identify below, the individual whose protected health information will be disclosed:

Name: _____ Birth Date: _____ / _____ / _____
MM DD YR

Address: _____ Home Telephone No.: _____
_____ Work Telephone No.: _____
_____ E-mail Address: _____

Last 4 digits of the Covered Employee's Social Security Number: _____

PURPOSE OF AUTHORIZATION

Unless use and disclosure is otherwise allowed or required by law, this Authorization is required for the Health Plan to release health information to someone other than the individual who is the subject of the information, or to use or disclose health information for purposes outside the Health Plan's normal operations (e.g., treatment, payment of claims or healthcare operations). The recipients of this Authorization will rely on it to use and disclose the individual's health information. Please review it carefully.

NATURE OF DISCLOSURE BEING AUTHORIZED

The information requested in Questions 1 through 7 must be provided for this Authorization to be effective.

- 1. Describe Information To Be Disclosed:** Identify here what you authorize to be used or disclosed. The information should be specific such as "Information related to my knee surgery":

List information here: _____

- 2. Describe the Purpose of the Disclosure:** List why the information is being disclosed. If you are initiating the request, you can simply list "At the request of the individual."

List purpose: _____

Effect of Disclosure. I understand that if the persons to whom my health information is disclosed are not subject to the HIPAA Privacy Rule (i.e. are not a health plan, health care provider or health care clearinghouse), the disclosed health information may no longer be protected by the HIPAA Privacy Rule and may be redisclosed without my authorization.

Retention and Right to Copy. I understand that a Covered Entity which receives this Authorization must retain a copy and that I am required to receive a signed copy as well.

Provisions Related to Psychotherapy Notes. I understand that an Authorization is required for any use or disclosure of psychotherapy notes except in the limited situations dealing with treatment, training or defense of legal actions as defined in 45 CFR 164.508(a)(2).

Records Related to STD, or Alcohol or Chemical Dependency. I understand that if the health information that I have authorized be disclosed under Question 1, includes information regarding testing, diagnosis or treatment for HIV/AIDS, sexually transmitted diseases, or drug or alcohol use, that I am authorizing the disclosure of this information.

PERSONAL REPRESENTATIVE

This section only needs to be answered if this authorization is being completed by someone other than the individual who is the subject of the health information.

The Health Plan, for purposes of the Privacy Rule will treat a properly designated personal representative as the individual without the need for an authorization. This will apply when the individual is deceased, a personal representative has been designated in accordance with applicable law, or the individual is an unemancipated minor and state law does not prohibit disclosure to a parent or other guardian. The Health Plan reserves the right to decline to recognize an individual as a personal representative if there is a reasonable belief that the individual whose information would be disclosed has been or could be subject to abuse, neglect or endangerment by disclosure. Disclosure also will not be made if inconsistent with applicable law.

Except as limited by state law of the Privacy Rules, no authorization is needed to disclose information to a natural parent or legal guardian of an unemancipated minor.

- a. Name of Personal Representative: _____
- b. Basis for Being Personal Representative (e.g. parent, executed health care power of attorney, etc.) Attach a copy of any document creating your authority to act for the named individual.

Address: _____ Telephone No.: _____
_____ E-mail Address: _____

Signature: _____ Date: _____