NECA – LOCAL NO. 145 IBEW WELFARE PLAN

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 NECA – LOCAL NO. 145 IBEW WELFARE PLAN ("Plan") to share protected health information with the person(s) designated below.

Section 1: Recipient of Information

I, _____, give permission for the Plan to share the following information with _____ (Print Name of Person or Entity):

☐ my protected health information (designated in Section 2); or

☐ protected health information (designated in Section 2) for the following person(s):

_____

_____

_____

Section 2: Description of Information to be Released

☐ 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 3: Purpose for Disclosure

Check one: ☐ At my request. ☐ Other_____

Section 4: 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 Plan or you revoke your authorization in writing. Additionally, unless you revoke this authorization in writing, you further agree that this authorization will remain in effect during all periods of your eligibility (including periods of eligibility between periods of ineligibility). Your request to revoke this authorization will be effective the day it is received by the Benefits Office. Note, any use or disclosure made prior to the revocation of this authorization will not be affected by the revocation.

Section 5: Approval and Signature

I understand that this authorization to release protected health information is voluntary and is not a condition of enrollment in the Plan, eligibility for benefits, or payment of claims. I also understand that if the person(s) or entity 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.

INSTRUCTIONS FOR COMPLETING THE AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION FORM

FOLLOW THESE STEPS TO COMPLETE THE FORM CORRECTLY. FOR THE AUTHORIZATION TO BE VALID, YOU MUST COMPLETE THE ENTIRE FORM.

SECTION 1: SPECIFY WHO IS COVERED BY THE AUTHORIZATION

1. Enter Your Full Name in the space provided.
2. Enter the Name of the Person or Entity who you are authorizing to receive protected health information
3. If you are disclosing your personal health information, check the applicable box. If you are authorized to execute this form for another person and are authorizing the disclosure of information for such other person, check the applicable box and identify the other person(s).

NOTICE: A separate authorization must be completed by the Participant, the Participant's Spouse, and the Participant's Adult Dependent, as applicable, to enable the Plan to disclose protected health information. For example, an Adult Dependent of the Participant must each sign an authorization form to permit the Plan to disclose information regarding the Participant's Adult Dependent to the Participant.

SECTION 2: SELECT INFORMATION TO BE SHARED

Choose What to Share – Check one or more boxes:

☐ Eligibility Information – Includes hours worked, dates of eligibility, COBRA eligibility, and self-payments.
☐ Medical Claims Information – Includes diagnoses, treatment dates, payment details, and medical conditions (including substance abuse, communicable diseases, etc.). Psychotherapy notes are excluded.
☐ Other – Write in any specific information you wish to share.

SECTION 3: REASON FOR SHARING

Check one:

☐ "At my request" – Use this if no specific reason is needed.
☐ "Other" – Write in your specific reason (e.g., union assistance, employment verification, etc.).

SECTION 4: WHEN THIS AUTHORIZATION EXPIRES

Check only one box:

☐ "The later of when I revoke this authorization or when I lose eligibility with the Fund." → This keeps the authorization in effect until you cancel it or your coverage ends.
☐ "Upon the following date:" → Write a specific expiration date if you want to set one.

To revoke this authorization later, you must REVOKE this authorization in writing and provide it to the Fund Office.

SECTION 5: SIGN AND DATE

1. Sign your name to approve the release.
2. Print your name clearly.
3. Write the date you sign.

IF SOMEONE ELSE IS SIGNING ON YOUR BEHALF

If you're not signing for yourself, the signer must:

1. Check the correct status of the individual: ☐ Minor ☐ Legally Incompetent ☐ Deceased
2. Check the legal authority: ☐ Parent ☐ Legal Guardian ☐ Power of Attorney ☐ Executor
3. Be prepared to provide proof of their legal authority (e.g., court order, power of attorney document).

RETURN THE COMPLETED FORM TO:

NECA – LOCAL NO. 145 IBEW WELFARE PLAN
1700 52nd Ave., Suite B
Moline, IL 61265
Phone: (309) 757-7551 (Nicole Hooks)
Fax: (309) 764-3438