Central Laborers' Welfare Funds

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Since the inception of the Federal HIPAA Privacy regulations, April 2003, Central Laborers' Welfare Fund has had to limit the information released to any individual, other than you, when it came to discussion related to your Health & Welfare Benefits. Often, this caused problems because the Fund could not talk to a spouse regarding a Participant's claims, a parent regarding an 18 year old or older dependent's claims or to a Local Union representative who wanted to help you resolve issues with your eligibility or Welfare Fund Benefits. In an effort to reduce the imposition caused by the HIPAA regulations, Central Laborers' Welfare Fund is providing you the opportunity to give us permission to discuss your Welfare Fund Benefits with individuals you designate.

By completing the Central Laborers' Welfare Fund Adult Authorization to Release Protected Health Information form on the back of this letter you are giving the Fund permission to discuss or share specific information from your personal health records or regarding your benefits, both of which the Fund would otherwise be restricted from sharing. The form is simple to complete and only requires you to do the following (all areas to complete have been highlighted in gray):

1. Review the form.
2. Fill out Section 1, writing in the name of a person or persons (example – your Spouse, your Parent or other person) you are giving the Fund permission to speak to or share information with in the future.
3. Fill out Section 2, writing in the name of your Local Union or your employer (example – LL# 477or Wicker Construction) if you want the Fund to speak or share protected health information with that representative.
4. Check the type of information you are giving Central Laborers' Welfare Fund permission to discuss or share with person(s) designated in Section 1 and Section 2.
5. Sign and date your authorization.
6. Return the form in the envelope included.

Central Laborers' Welfare Fund will never release information that you have not specified on the form, nor will the Fund discuss your protected health information with anyone other than the individual(s) you identified on the form or as required or allowable under the HIPAA Privacy regulations.

You always have the right to revoke your authorization, should you no longer want Central Laborers' Welfare Fund to discuss your Health & Welfare benefits with the designated individual(s). To revoke your authorization, you simply need to complete the Revocation Form that can be downloaded from www.central-laborers.com or you may request one by calling the Fund Office. Please be aware, a request to revoke your authorization will be effective on the date it is received in the Fund Office.

If you have questions, concerns or need assistance completing the form, do not hesitate to contact the Fund Office at 1-800-252-6571.

Sincerely,
Central Laborers' Welfare Fund

CENTRAL LABORERS' WELFARE FUND
ADULT AUTHORIZATION
TO RELEASE PROTECTED HEALTH INFORMATION

Federal law prohibits insurers from sharing your health information without your permission except in certain situations. This form provides your permission for Central Laborers' Welfare Fund to share protected health information with the person(s) you designate below. Please be advised that Central Laborers' has no control over your protected health information once it is disclosed to the Recipient designed below. ***Please be further advised that this authorization does not prevent the information from being shared with other persons once such information is disclosed (verbally or in writing) to the Recipient designated below.*** This authorization will remain in effect until the date your eligibility ends under Central Laborers' Welfare Fund or you revoke your authorization by completing and submitting a REVOCATION FORM. A REVOCATION FORM can be found on the Central Laborers' Welfare Fund website www.central-laborers.com or by requesting one from the Fund Office at 1-800-252-6571. Your request to revoke this authorization will be effective the day it is received by the Fund Office.

I, _____, Policy ID: _____, give permission for Central Laborers' Welfare Fund to share my protected health information as designated below:

1. **Share with _____, the following Information:**
   NAME OF THE PERSON YOU WANT TO RECEIVE INFORMATION
   (EXAMPLE – YOUR SPOUSE'S FULL NAME OR A DEPENDENT'S FULL NAME)
   - ☐ **ELIGIBILITY INFORMATION (INCLUDING MY HOURS, DATES OF ELIGIBILITY AND SELF-PAYMENTS)**
   - ☐ **MEDICAL CLAIM INFORMATION (INCLUDING PAYMENT, PROCEDURE AND DATES OF SERVICE.**
   - ☐ **ALL INFORMATION RELATED TO MY ACCOUNT**
   - ☐ **OTHER _____**

2. **Share with representatives of _____, the following information:**
   LOCAL UNION OR EMPLOYER TO RECEIVE INFORMATION
   (EXAMPLE – LL #477 OR WICKER CONSTRUCTION)
   - ☐ **ELIGIBILITY INFORMATION (INCLUDING MY HOURS, DATES OF ELIGIBILITY AND SELF-PAYMENTS)**
   - ☐ **MEDICAL CLAIM INFORMATION (INCLUDING PAYMENT, PROCEDURE AND DATE OF SERVICE.**
   - ☐ **ALL INFORMATION RELATED TO MY ACCOUNT**
   - ☐ **OTHER _____**

This health information described above is being disclosed per my request.

Neither Central Laborers' Welfare Fund nor the entity receiving the information above may condition treatment, payment, enrollment or eligibility for benefits on whether you sign this authorization.

_____ _____

YOUR NAME/AUTHORIZED REPRESENTATIVE **YOUR /AUTHORIZED REPRESENTATIVE'S SIGNATURE**

_____

DATE