CENTRAL LABORERS' WELFARE FUND AUTHORIZATION
For the Use and Disclosure of
Health Information

Federal law says that we cannot share your health information without your permission except in certain situations. If you sign this form, you are giving us permission to share the health information you indicate below. *This does not keep the information from being shared with more people once It leaves our offic*e. This authorization will only last until the date you specify, but not longer than one year. If you decide later that you do not want us to share your information any more, you can sign the REVOCATION SECTION at the end of this form and return it to us.

Date: ____

Person or Group Needing the Health Information: ____________________________

I give permission to ____________________________________ to share the health information checked below with the person or group listed above:

- ❑ **All information**
- ❑ **Information from a certain time period (specify dates):**
  From _____________________________ To ____________________________
- ❑ **All information relating to a certain event or injury -- *example: left knee injury from December 2000* (specify event and dates):**
  Event ____
  Date of event ____
- ❑ **Other (specify): ____**

Printed Name:________________________ Signature___________________________

Signature of Authorized Representative__________________Date_______________

Relationship of Authorized Representative_____________________________________

REVOCATION SECTION

I no longer want my information shared.

Signature_____________________________ Date_____________________________

HIPAA Authorization

Original to agency
Copy to signer

Central Laborers' Welfare Fund
040803