Heating, Piping and Refrigeration Medical Fund

Physical Address: 8700 Ashwood Dr. Suite 150, Capitol Heights, MD 20743
Phone: (410) 444-3756 or (800) 618-2879 • Fax: (240) 303-2484 • Website: HPRBenefitFunds.com
Administered by
Welfare & Pension Administration Service, Inc.

AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

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

Last Name	First Name	Middle Initial

Member WPAS ID #	Date of Birth (MM/DD/YYYY)	Email

Home Phone Number (include area code)	Work Phone Number (include area code)

Street Address	City	State	Zip

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."*

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."*

3 **Identify Who Is Authorized to Disclose the Information:** Identify here who is authorized to make the disclosure. Be specific such as the "Trust Office." Check each box that applies:

☐ All entities with information about the matters listed in Question 1.

☐ Only the following entities:

4 **Identify Who Will Receive the Information:** List here who is authorized to receive information such as "*Mary Jones, my spouse*" or "*John Doe, my union representative.":*

5 **Identify How to Provide Information:** Where and how should the information be disclosed? List address, e-mail, facsimile, etc. Please remember that the information being sent is your private health information.

6 **Expiration Date of Authorization:** Indicate when your authorization will end. This can be a date ("*12/31/2024*") or upon the occurrence of an event (*"when decision is reached on my appeal")*. Unless otherwise indicated this authorization will be good for one year. Choose and complete one:

a. ☐ Authorization will end on the following date (MM/DD/YY):

b. ☐ Upon the occurrence of the following event:

7 **Signature and Date:** This document must be signed and dated.

Signature	Date

STATEMENT OF RIGHTS REGARDING THIS AUTHORIZATION

General Rights. I understand I am not required to sign this form and that a Covered Entity receiving it cannot condition treatment, payment, or eligibility on my decision to sign this form. I understand, however, that a health plan can condition enrollment in the Plan or eligibility for benefits on receiving an authorization if the purpose is to allow the health plan to obtain information it needs to make eligibility, enrollment or underwriting decision and psychotherapy notes are not requested.

Right to Revoke. I understand that I have the right to revoke this authorization in writing except as to uses and/or disclosures already made in reliance on it. Authorization revocation forms can be obtained by contacting the Contact Person listed in my Health Plan's Privacy Notice.

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 re-disclosed 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 164.5089(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 purpose 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 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.

Name of Personal Representative			
Basis for Being Personal Representative (e.g. parent, executed health care power of attorney, etc.)			
Phone Number (include area code)	**Email**		
Street Address	**City**	**State**	**Zip**

Personal Representative Signature	Date

Attach a copy of any document creating your authority to act for the named individual.