Duluth Building Trades Health Fund

2002 London Road – Suite 300
Duluth, MN 55812-2152

Wilson-McShane Corporation
Fund Administrators

Telephone: (218) 728-4231
Fax: (218) 728-4773
Toll Free: (800) 570-1012

IMPORTANT NOTICE

Re: Protected Health Information Release Form

Since April 14, 2003, the Duluth Building Trades Health Fund has been required by law to protect the privacy of your health information. In order to assist you and/or your family with information about your benefits or should you become unable to speak for yourself, it is imperative you carefully read the enclosed information and designate a personal representative.

If we do not receive this form from you, we cannot under the HIPAA privacy law, release necessary information to your family regarding your benefits.

Enclosed is a Protected Health Information Release Form you may use to authorize the Duluth Building Trades Health Fund and its Business Associates to release relevant health information to your Authorized Representative. A Business Associate is a person or company that may create or use health information while acting on behalf of the Fund.

If you have any questions about this form, please contact the Fund Office at (218) 728-4231 or (800) 570-1012

Sincerely,

Board of Trustees Duluth Building Trades Health Fund

Duluth Building Trades Heath Fund

Authorization for Release of Protected Health Information (PHI) By the Health Fund

You <u>MUST</u> complete all of the information requested in this form for your authorization to be valid.

I authorize the Fund the use of disclosure of my Protected Health Information (PHI) as described in this authorization. I understand the Fund may not condition my treatment, payment, enrollment or eligibility for benefits on whether or not I give the authorization listed in this form.

(1) **<u>The Plan can release PHI to:</u>** The Fund, its agents or subcontractors ("Business Associates") is authorized to release the PHI described below to the following person, class of persons, or organization:

□ My spouse □ My Union

□ My parents □ My Employer

□ Other (Print Name or Position): _____

(2) **<u>The information that may be used or released is:</u>**

□ Medical information held by the Fund from the following doctor, clinic, or hospital:

_____

□ Information held by the Fund concerning my eligibility, claims decisions and payments.

□ Other. Please specify below.

_____

_____

(3) **<u>Right to revoke:</u>** I understand that I have the right to revoke this authorization at any time by notifying the Fund's Contact Person in writing at the address listed at the top of this Form. I understand that the revocation is only effective after it is received and logged by the Fund. I understand that any use or disclosure made prior to the revocation under this authorization will not be affected by a revocation.

(4) **<u>Re-Release of Information:</u>** I understand that after this information is released, federal law might not protect it and the recipient might re-release it. I also understand and agree to hold the Fund and any of its agents and subcontractors harmless if the information is re-released.

(5) **<u>Copy:</u>** I understand that the Fund will give me a copy of this authorization if requested.

(6) **THE AUTHORIZATION WILL EXPIRE ON THE DATE ON WHICH YOUR ELIGIBILITY UNDER THE PLAN TERMINATES UNLESS YOU SPECIFY ANOTHER DATE OR TERMINATION EVENT BELOW.**

□ Other: _____

Your Signature: _____ Date: _____

Print Your Name: _____

If you are covered under the Fund as a Dependent, please print the name and social security number of the covered employee:

Name: _____ SSN: _____

<u>Mail or Fax Completed Forms to the Fund Administrator:</u>

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