International Union of Operating Engineers
Local No. 132 Trust Office
P.O. Box 2626 Huntington, West Virginia 25726-2626
(304) 525-0482 or 1-800-642-3525 www.iuoe132.org

HEALTH & WELFARE FUND

Authorization to Disclose Protected Health Information to my Designee

Protected Health Information is individually identifiable health information, including demographic information, collected, created or received by a health care provider, a health plan, my employer, or a health care clearinghouse and relates to your past, present and/or future physical or mental health or condition; the provision of health care to you; or the past, present or future payment for the provision of health care to you.

In order for the Health & Welfare Fund to answer questions about your Health & Welfare claims and eligibility with anyone other than you, we must have your permission. This authorization only applies to information that the Health & Welfare Fund has on file and as it pertains to the processing of your medical claims.

Participant Authorization

______________________________ Participant Name

______________________________ ID Number or SSN

I authorize the IUOE Local 132 Health & Welfare Fund to disclose my protected health information for me as it relates to the processing of claims and eligibility to the individual named below:

Name of authorized person: ______________________________ Relationship: ______________________

I understand that I may revoke this authorization at any time by writing to the IUOE Local 132 Health & Welfare Fund, 636 Fourth Avenue, Huntington, WV 25701-1321 and this revocation will be effective for future uses and disclosures of protected health information. I further understand this revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed.

➔ ______________________________ Participant's Signature

➔ ______________________________ Date

Spouse or Dependent Authorization

______________________________ Spouse or Dependent Name

______________________________ ID Number or SSN

I authorize the IUOE Local 132 Health & Welfare Fund to disclose my protected health information for me as it relates to the processing of claims and eligibility to the individual named below:

Name of authorized person: ______________________________ Relationship: ______________________

I understand that I may revoke this authorization at any time by writing to the IUOE Local 132 Health & Welfare Fund, 636 Fourth Avenue, Huntington, WV 25701-1321 and this revocation will be effective for future uses and disclosures of protected health information. I further understand this revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed.

➔ ______________________________ Spouse or Dependent

➔ ______________________________ Date

Important: If you are a spouse of a former participant and now covered under your own ID number, please complete the top section of this form as you are now the participant.