Instructions for Completing an Authorization Form

How to Authorize UNITE HERE HEALTH's Disclosure of an Individual's Protected Health Information to a Person or Organization

IMPORTANT: You must fill out all of the numbered sections of the form. If you do not, the form will be returned to you for completion. If any of the information you provide does not match the UNITE HERE HEALTH's records, the Authorization may be returned to you for more information.

1. Participant Information – ***the Participant is the employee (the insured)***

Print the Participant's social security number or Fund ID Number, name, date of birth, address and phone number. The information on the Authorization will be compared to information at the Fund Office to verify the identity of the Participant.

2. Patient Information – ***the Patient is the person who is giving permission for their health information to be released.***

Print the Patient's name, date of birth, address, phone number and their relationship to the Participant. If the Participant is the Patient, you can check the box beside "Patient is the Same as the Participant", and you do not have to fill out the remaining information in Section 2. The information on the Authorization form will be compared to information at the Fund Office to verify the identity of the Patient.

3. Person or Organization Receiving the Information

Print the name of the person or organization you (the patient) are authorizing the Fund to share your health information with.

4. Information to Be Released

Check the boxes provided for the types of information to be released. You can check more than one box. If you are allowing "any and all" information to be released, check the box marked "Any and all information". Check "other" if you want to be more specific about the information to be released, for example:

- Information on treatment by Dr. Smith from May 1, 2002 to May 5, 2010;
- The claims payment for all care from March 31, 2009 through April 15, 2010; or
- The reasons for the denial of benefits for services provided on June 24, 2010 at the XYZ clinic.

5. Purpose of Use/Disclosure

You may check the box "at my request" **or** you may write in a more specific reason as to why you want the Fund to disclose information to the person or organization you listed.

6. Expiration of the Authorization

You must provide an expiration date of when the Authorization will expire. If you do not provide a date, the Authorization will expire one year from the date it is signed by the Patient (or legal guardian).

7. Signature and Date

The Patient (the person listed under #2) **must sign and date** the form or it will be considered invalid. If the patient is a minor the form should be signed by a custodial parent or legal guardian. If the form is signed by a legal guardian or other legal representative, this person's name and relationship to the Patient must be entered on the second line. The Fund may require proof of legal custody or guardianship.