BENEFIT • PENSION • ANNUITY
IW TRUST FUNDS
Building Futures Together

1470 Worldwide Place • Vandalia, OH 45377-1156
Phone (937) 454-1744 • Fax (937) 454-5457

AUTHORIZATION FORM

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I, _____ hereby authorize the use or disclosure of my health information as described in this authorization. Last four digits of the Ironworkers Social Security Number _____.

1. Specific person/organization authorized to provide the information:

_____

_____

2. Specific person/organization authorized to receive and use the information:

_____

_____

3. Specific and meaningful description of the information:

Please choose one of the following to describe the written, electronic and/or oral information you wish the Trust to disclose:

A. Related to eligibility for benefits for the time period commencing on _____ (date) and continuing through _____ (date).

B. Including claims, reports, and other documents related to claims for benefits for an injury or illness commencing on _____ (date) and continuing through _____ (date).

C. Relating to payment or lack of payment of benefits to _____ [name of health care provider] for services rendered on _____ (date).

D. Other (specify type of information and dates).

_____

_____

4. Purpose of the request: Please state the purpose of the request below. [*E.g., to discuss my benefits with the Trust and its Business Associates so that I can better understand my benefits.*] If you do not wish to state a purpose, please state, “At the request of the individual.”

_____

_____

5. Right to Revoke: I understand that I have the right to revoke this authorization at any time by notifying the Administrative Manager in writing at Iron Workers District Council of Southern Ohio and Vicinity Benefit Trust, 1470 Worldwide Place, Vandalia OH 45377-1156. I understand that the revocation is only effective after it is received and logged by the Administrative Manager. I understand that any use or disclosure made prior to the revocation under this authorization will not be affected by a revocation.

6. I understand that after this information is disclosed, federal law might not protect it and the recipient might disclose it again.

7. I understand that I am entitled to receive a copy of this authorization.

8. I understand that this authorization will expire on [*insert an expiration date or event, for example, one year*].

9. The Trust will not condition treatment, payment, enrollment or eligibility for health plan benefits on receipt of an authorization.

OR

The Trust may condition enrollment in the plan or eligibility for health plan benefits on receipt of authorization prior to enrollment, if the authorization is sought for underwriting or risk rating determinations and does not relate to psychotherapy notes.

I certify that I have reviewed the Trust's Policy for Recognition of Personal Representative.

Participant or Beneficiaries' Signature _____ Date _____

Authorized Representative's Signature _____ Date _____

******MUST BE NOTORIZED******

NOTARY SIGNATURE AND AFFIX SEAL: _____ DATE: _____

NOTARY PRINTED NAME: _____

NOTARY PUBLIC, STATE OF _____, COUNTY OF _____

MY COMMISSION EXPIRES: _____, 20_____.