

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I, _____, **[Individual Name]** hereby authorize the United Food and Commercial Workers & Employers Arizona Health & Welfare Trust (the "Plan") to disclose my health information as described in this authorization. This authorization shall also apply to the following designated business associate of the Plan (to the extent the business associate maintains the information that is the subject of this Authorization):

_____ (*insert name of business associate authorized to release information pursuant to this authorization*).

(1) *Specific person/organization (or class of persons) to whom the Plan is authorized to disclose the information:*

(2) *Specific description of the information to be disclosed by the Plan:*

(3) *Right to Revoke:* I understand that I have the right to revoke this authorization at any time by notifying the Plan in writing at 2400 West Dunlap, Suite 250, Phoenix, Arizona 85021-2811. I understand that the revocation is only effective after it is received by the Plan. I understand that any use or disclosure made prior to the revocation of this authorization will not be affected by the revocation.

(4) *Potential for Rediscovery:* I understand that after this information is disclosed, federal law might not protect it, and the recipient might redisclose it

(5) *Right to Copy:* I understand that I am entitled to receive a copy of this Authorization.

(6) *Expiration of Authorization.* This authorization will expire **[choose and complete one]**.

___ On the ___ day of _____, 201___.

___ Upon the occurrence of the following event: _____

(7) *Voluntary:* I understand that I am under no obligation to sign this form. I acknowledge I am voluntarily signing this form to release my health information to the party I have designated.

(8) *Benefits Not Conditioned on Form:* I understand that the Plan may not condition enrollment in the Plan or eligibility for benefits on this authorization form unless the purpose of this authorization form is to allow the Plan to obtain information it needs to make an eligibility, enrollment or underwriting determination.

(9) *Purpose of Authorization:* I am requesting that my information be disclosed for the following purpose (individual can simply state “pursuant to individual authorization”): _____

(10) *Photocopy and Facsimile:* A photocopy or facsimile of this signed authorization form shall be considered as valid as an original signed copy.

I have had an opportunity to review and understand the contents of this form. By signing this form, I am confirming that it accurately reflects my wishes.

_____ (Date) _____ (Print Name)

(Signature)

Plan Participant's Social Security Number					-			-				
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Personal Representative section

If a Personal Representative executes the form on behalf of the individual, the Personal Representative warrants that he or she has authority to sign this form on the basis of: (check one)

_____ A power of attorney for health care purposes including the right to access protected health information, notarized by a notary public (copy attached).

_____ A court order of appointment of the person as the conservator or guardian of the individual (copy attached).

_____ An individual who is the parent of an unemancipated minor child may generally act as the child's representative (subject to state law exceptions).

_____ Other: _____

