Instructions for Completing an
Authorization for Release of Protected Health Information

1. **Complete the “Authorization for Release of Protected Health Information” form in its entirety.**
   Print clearly in blue or black ink and answer all questions. If the form is not legible, if a question is left unanswered or if the form is not signed it will be returned to you for completion. **An Authorization for Release of Protected Health Information Form must contain an expiration date, a signature and date to be valid.** If you are submitting the “Authorization for Release of Protected Health Information” form other than in person, for identification purposes, you **must** also submit a copy of a government issued identification card. Acceptable forms of ID include a driver’s license, state ID, passport or resident alien identification card. If you are unsure of what forms of ID are acceptable, please contact the Fund office at 312-787-9455 and press phone option 3 to speak with a Participant Services representative Monday through Friday from 8:00 AM to 4:30 PM.

2. **Submit the fully completed and signed “Authorization for Release of Protected Health Information” form to:**

   - **Scan & Email:** Appeals@crccbenefits.org
   - **Fax:**
     Chicago Regional Council of Carpenters Welfare Fund
     Attn: HIPPA Privacy Officer
     Fax Number: 312-951-1515
   - **Mail:**
     Chicago Regional Council of Carpenters Welfare Fund
     Attn: Participant Services Department
     12 East Erie Street
     Chicago, IL  60611

**Important Note:**

- **✓** Only the attached Authorization for Release of Protected Health Information form will be accepted by the Chicago Regional Council of Carpenters Welfare Fund. **No other authorization for release of protected health information forms will be accepted.**
- **✓** The Plan will automatically recognize any person who holds a legal Healthcare Power of Attorney for an individual as that individual’s personal representative.
- **✓** A Power of Attorney will not be accepted unless it specifically addresses decisions related to healthcare.

March 2014
Authorization for Release of Protected Health Information

I, _________________________________ [name of individual] hereby authorize the use or disclosure of my health information as described in this authorization.

1. Specific person/organization (or class of persons) authorized to provide the information:
   ____________________________________________________________________________________
   ____________________________________________________________________________________

2. Specific person/organization (or class of persons) authorized to receive and use the information:
   ____________________________________________________________________________________
   ____________________________________________________________________________________

3. Specific and meaningful description of the information:
   Please describe the information you wish the Plan to disclose.

   Examples:
   a. Written, electronic and oral information related to eligibility for benefits for the time period commencing on _______ [date] and continuing through __________ [date].
   b. Written, electronic and oral information including claims, reports, and other documents related to claims for benefits for an injury or illness commencing on _______ [date] and continuing through _______ [date].
   c. Written, electronic and oral information relating to payment or lack of payment of benefits to [name of health care provider] for services rendered on _______ [date].
   ____________________________________________________________________________________
   ____________________________________________________________________________________

4. Please state the specific purpose of the request below.
   ____________________________________________________________________________________
   ____________________________________________________________________________________

5. Right to Revoke: I understand that I have the right to revoke this authorization at any time by notifying the Privacy Official in writing at:
   Privacy Official
   Chicago Regional Council of Carpenters Welfare Fund
   12 East Erie Street
   Chicago, Illinois 60611

6. I understand that the revocation is only effective after it is received and logged by Privacy Official. I understand that any use or disclosure made prior to the revocation under this authorization will not be affected by a revocation.

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

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

9. I understand that this authorization will expire on ____________ [insert an expiration date or event, for example, today’s date].

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

___________________________________ ______________________  __________________
Signature of Individual    ID# or SS#    Date

If a Personal Representative executes this form, that Representative warrants that he or she has authority to sign the form on the basis of: (Please attach a copy of the signed document authorizing you to act as a Personal Representative.)

March 2014