Teamsters Health & Welfare Fund
of Philadelphia and Vicinity

6981 N. PARK DRIVE, SUITE 400 • PENNSAUKEN, NJ 08109 • (856) 382-2400
TOLL-FREE (800) 523-2846 • FAX (856) 382-2401 • www.teamsterfunds.com

INSTRUCTIONS FOR COMPLETING THE HIPAA FORM

Participant Name/Social Security Number - Refers to the person whose information is being disclosed.

Item 1. Please list information that can be released.
(Example: All information related to medical/dental/vision/claims.)

Item 3. Please list person(s) who may receive information.
(Example: mother, father, name of law firm.)

Item 4. Please list purpose ("At my request" is sufficient).
(Example: Review health/billing information.)

Item 6. Please list an expiration date. The HIPAA form must have an expiration date, but it doesn't need to be a specific date; it can be an event related to the individual or the reason for the form.
(Example: When the participant terminates coverage in the plan.)
(Example: At the end of litigation.)

PLEASE NOTE:

- The HIPAA form must be completed in its entirety with all necessary information provided for it to be in effect. Incomplete forms will be returned for completion.
- Minor Children – Children under the age of 18 would have the parent and/or guardian complete the form in its entirety.
- The HIPAA form is for individual use.
(Example: If you want to have disclosure forms for yourself, your spouse, and one child, three HIPAA forms would be required).

If you should have any questions regarding the above, please contact the Member Services Department at 1-800-523-2846 or 1-856-382-2400.

To fax your forms, 1-856-382-2402 or 1-856-382-2401.

TEAMSTERS HEALTH & WELFARE FUND

Of Philadelphia and Vicinity

Authorization to Disclose Protected Health Information

[A separate authorization must be used if the authorization is for psychotherapy notes.]

Participant Name: _____ Birth Date: _____/_____/____
MM / DD / YR

Address: _____

_____

_____

Home Telephone Number: _____ E-mail: _____

Work Telephone Number: _____

Participant Identification Number and/or Social Security Number: _____

By signing this authorization form I authorize the person(s) and/or organization(s) described below to use and/or disclose my health information (information that constitutes protected health information as defined in the Privacy Rule of the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996) in the manner described below. I understand that I am under no obligation to sign this form. I have signed this form voluntarily to document my wishes regarding the use and/or disclosure of the health information described below in Section 1 of this form.

1. Description of Health Information I Authorize to be Used or Disclosed. The following is a specific description of the health information I authorize be used and/or disclosed: (Specify and provide a meaningful description.)

_____

_____

2. I authorize the Teamsters Health & Welfare Fund of Philadelphia and Vicinity ("Health & Welfare Fund"), to use and/or disclose the health information described above in Section 1 of this form.

3. Persons/Organizations Authorized to Receive and/or Use My Health Information. I authorize the following person(s) and/or organization(s) (or classes of persons and/or organizations) to receive my health information from the person(s) and/or organization(s) described in Section 2 above and to use or disclose such information for the purposes listed below in Section 4 of this form. I understand that if the person(s) and/or organization(s) listed below are not health care providers, health plans or health care clearinghouses subject to federal privacy standards, the health information disclosed pursuant to this authorization may no longer be protected by the federal privacy standards and such person(s) and/or organization(s) may re-disclose my health information without obtaining my authorization.

_____

_____

4. Description of Each Purpose for the Requested Use and/or Disclosure. I authorize my health information to be used and/or disclosed for the following specific purposes:

_____

_____

5. Your Rights with Respect to This Authorization.

5.1 Right to Revoke. I understand that I have the right to revoke this authorization at any time. I also understand that my revocation of this authorization must be in writing. To obtain a copy of an authorization revocation form I may contact the Health & Welfare Fund's Privacy Officer at 6981 N. Park Drive, Suite 400, Pennsauken, NJ 08109, (856) 382-2400. I am aware that my revocation will not be effective as to uses and/or disclosures of my health information that the person(s) and/or organization(s) identified in Sections 2 and 3 of this form have already made in reliance upon this authorization.

5.2 Right to Receive Copy of This Authorization. I understand that if I agree to sign this authorization, which I am not required to do, I must be provided with a signed copy of it.

6. Expiration of Authorization. This authorization will expire (choose and complete one):

☐ On _____/_____/_____
MM / DD / YR

☐ Upon the occurrence of the following event(s) related to my health care or the purpose(s) for which I have authorized the use and/or disclosure of my health information described in Section 4 of this form: _____

_____

I, _____ (please print name), 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.

_____ _____/_____/_____
Participant Signature Date

If signed by a personal representative, complete the following:

Name of personal representative: _____

Relationship to participant or nature of authority (e.g., health care power of attorney, parent of child under the age of 18, guardian, other statutory authorization): _____

Address: _____
_____
_____

Home Telephone Number: _____ E-mail: _____
Work Telephone Number: _____

_____ _____/_____/_____
Signature of Personal Representative Date