KENTUCKY LABORERS DISTRICT COUNCIL HEALTH & WELFARE FUND
HIPAA AUTHORIZATION FORM [LOCAL UNION REPRESENTATIVES]

PARTICIPANT'S FULL NAME	**PARTICIPANT'S SOCIAL SECURITY NUMBER / ID NUMBER**
ADDRESS	**PARTICIPANT'S DATE OF BIRTH**
CITY, STATE ZIP CODE	**PARTICIPANT'S TELEPHONE NUMBER**

I hereby authorize the use or disclosure of any and all protected health information about me as described below.

1. This authorization is only for use by the Kentucky Laborer's District Council Health and Welfare Fund's Administrative Office and is authorized to use or disclose information about me to:

   Name of Union Official:_____

   Address of Union Official:_____

2. Specific information that should be disclosed is any information requested regarding my eligibility or lack thereof for being a covered participant in the plan and _____
   _____
   _____.

UNLESS YOU SIGN HERE, NO INFORMATION ABOUT ALCOHOL/SUBSTANCE ABUSE, HIV/AIDS, OR MENTAL HEALTH WILL BE DISCLOSED:

YES, I AUTHORIZE THE DISCLOSURE OF THIS INFORMATION *_____

NO, **I DO NOT AUTHORIZE** DISCLOSURE OF THIS INFORMATION * _____

3. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations.
4. I may revoke this authorization at anytime by notifying the Kentucky Laborers District Council Health and Welfare Fund **in writing**.
5. My purpose for the use of the information is for assisting me and determining my status under the plan and other matters specified.
6. This authorization expires on _____, 20____, OR upon occurrence of the following event that relates to me or the Purpose of the intended use of the disclosure of information about me: my death.

FEES FOR COPIES: Federal and state laws permit a fee to be charged for the copying of patient records. You may be required to pre-pay for the copies; if not, then your copies will be mailed along with an invoice.

THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING – note that signature is required in two places.*

Signature of Individual* (The person about whom this information relates)	**Date of Individual's Signature**	**Date of Birth or Social Security Number**

A copy of this completed, signed and dated form must be given to the Individual or other signator.

Official Use Only

Received	**Processed By**	**Log #**