**TEAMSTERS JOINT COUNCIL NO. 83 OF VIRGINIA HEALTH & WELFARE FUND**

**AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION**

**I hereby authorize the use or disclosure of my individually protected health information as described below.** I understand that information disclosed pursuant to this authorization may be redisclosed by the recipient and may no longer be protected by federal privacy laws, including HIPAA.

Participant's name: _____ ID Number: _____

Date of Birth: _____ Telephone #: _____E-Mail Address: _____

Person(s)/organization(s) providing information: _____

_____

_____

Person(s)/organization(s) receiving information: _____

_____

_____

**Information Authorized for Release (check all that apply):**

☐ Eligibility and Enrollment Information ☐ Claims and Payment Information ☐ Medical Records
☐ Prescription Drug Information ☐ COBRA Information ☐ Subrogation/Reimbursement Information
☐ Disability Claim Information ☐ All Health & Welfare Fund Records ☐ Other: _____

Specific description of information and dates (if applicable): _____

_____

Purpose of the use or disclosure: _____

_____

**Method of Disclosure:**

☐ Mail ☐ Secure Email ☐ Fax ☐ In-Person Pickup ☐ Other: _____

☐ I request disclosure by email and understand that unencrypted email may present privacy and security risks.

**The participant or the participant's representative must read and initial the following statements:**

1. I understand that the Fund may not condition my eligibility for benefits on my signing this authorization, except where permitted by applicable law. **Initials**: _____

2. I understand that I will receive a copy of this authorization after signing it. **Initials:** _____

3. I understand that this authorization expires on _____ or upon the following event: _____. **Initials:** _____

4. I understand that I may revoke this authorization at any time by notifying the Privacy Officer in writing, but revocation will not affect actions already taken in reliance on this authorization. **Initials:** _____

**Privacy Officer Contact Information**

Teamsters Joint Council No. 83 of Virginia Health & Welfare Fund
ATTN: HIPAA Privacy Officer
8814 Fargo Rd, Suite 200, Richmond, VA 22229
Email: documents@tjc83funds.net
Fax: 804-852-0806

**Representative Authority (if applicable): Documentation of authority must be attached if signed by a representative.**

☐ Power of Attorney ☐ Guardian ☐ Conservator ☐ Executor/Administrator ☐ Parent of Minor Child
☐ Other: _____

Participant Signature: _____ Date: _____

Representative Signature (if applicable): _____

Printed Name of Representative: _____

Relationship/Capacity: _____