INDIANA LABORERS WELFARE FUND
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HIPAA Authorization Form

This HIPAA Authorization is an optional form, and the Indiana Laborers Welfare Fund may not condition treatment, payment, enrollment or eligibility for benefits on whether or not this form is signed. If you are over the age of 18 and would like the Fund to discuss your personal health information (PHI) with someone other than yourself, this form must be completed and returned. PHI is individually identifiable information created or received by the Fund that relates to your past, present, or future physical or mental health condition; your health care providers; or the past, present or future payment for health care provided to you.

Your Name: _____	ID# or SSN: _____

The following person or class of persons/organizations is authorized to receive,use, and disclose my personal health information:

Name: _____ Relationship to You: _____

Name: _____ Relationship to You: _____

The specific information that should be disclosed is:_____.
(If you leave this field blank, you are consenting to no limitations on disclosure.)

My specific purpose for this disclosure is:_____.
(If you leave this field blank, you are consenting to a unlimited purpose.)

This authorization expires on ____/_____/_____, OR upon occurrence of the following event that relates to me or the purpose of this disclosure:_____. **(If you leave this field blank you are consenting to an indefinite expiration date.)**

1. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons/organizations receiving it, and it would not longer be protected by federal privacy regulations.
2. I understand that I may revoke this Authorization at any time prior to its expiration date by notifying in writing each person or class of persons/organizations I previously authorized. However, any revocation will not apply to the extent that we have already taken action in reliance upon your Authorization. Your request for revocation must be in writing. We will provide you with a revocation form at your request.
3. A copy of this signed and dated form will be mailed to you.

_____ _____
Signature (The person whose PHI is being disclosed.) Date