INDIANA LABORERS WELFARE FUND
P.O. BOX 1587 TERRE HAUTE, INDIANA 47808-1587
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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 this form is signed. If you are over the age 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.

PARTICIPANT/PATIENT INFORMATION	
Participant's Name:	**Participant's Date of Birth:**
Patient's Name (if different):	**Patient's SSN:**
Patient's Date of Birth:	**Patient's Address:**
Patient's Telephone:	**Patient's E-mail:**

I hereby authorize the use or disclosure of my protected health information as described below.

1. The following specific person or class of persons/organizations is authorized to **use and disclose** my personal health information:

   Name(s)

   Address(es)

   City, State, Zip Code

2. The following specific person or class of persons/organizations is authorized to **receive and use** my personal health information:

   Name(s)

   Address(es)

   City, State, Zip Code

3. The specific information that should be disclosed is (include relevant dates, if possible, *e.g.,* "MRI performed in December 2012" or "all health information"):

_____

_____

_____

4. 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 no longer be protected by federal privacy regulations.
5. 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, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.

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

7. This authorization expires on ____/_____/____, OR upon occurrence of the following event that relates to me or

   to the purpose of this disclosure: _____.
   (If you leave these fields blank, you are consenting to an indefinite expiration date.)

_____ _____

Signature of Participant/Patient (The person whose PHI is being disclosed.) **Date**

OR, IF APPLICABLE:

_____ _____ _____

Signature of Guardian or Personal Representative **Date** **Description of Authority to Act**

A copy of this <u>signed and dated</u> form must be given to the Participant/Patient or other Signator.