Heartland Healthcare Fund

Reset Form

Authorization for Release of Protected Health Information (PHI) By the Fund

You <u>MUST</u> complete all of the information requested in this form for your authorization to be valid.

I authorize the Plan the use and disclosure of my Protected Health Information (PHI) as described in this authorization. I understand the Plan may not condition my treatment, payment, enrollment or eligibility for benefits on whether or not I give the authorization listed in this form.

(1) **<u>The Plan can release PHI to:</u>** The Plan, its agents or subcontractors ("Business Associates") is authorized to release the PHI described below to the following person, class of persons, or organization:

☐ My spouse_____ ☐ My Union_____

☐ My parents_____ ☐ My Employer_____

☐ Other (Print Name or Position): _____

(2) **<u>The information that may be used or released is:</u>**

☐ Information held by the Plan concerning my eligibility, claims decisions and payments.

☐ Medical information held by the Plan from the **following doctor, clinic, or hospital**: (list specifics below)

_____

☐ Other. (list specifics below)

_____

_____

(3) **<u>Right to revoke:</u>** I understand that I have the right to revoke this authorization at any time by notifying the Plan's Contact Person in writing at the address listed at the bottom of this Form. I understand that the revocation is only effects after it is received and logged by the Plan. I understand that any use or disclosure made prior to the revocation under this authorization will not be affected by a revocation.

(4) **<u>Re-Release of Information:</u>** I understand that after this information is released, federal law might not protect it and the recipient might re-release it I also understand and agree to hold the Plan and any of its agents and subcontractors harmless if the information is re-released.

(5) **<u>Copy:</u>** I understand that the Plan will give me a copy of this authorization

(6) **THE AUTHORIZATION WILL EXPIRE ON THE DATE ON WHICH YOUR ELIGIBILITY UNDER THE PLAN TERMINATES UNLESS YOU SPECIFY ANOTHER DATE OR TERMINATION EVENT BELOW.**

☐ Other: _____

Your Signature:_____ Date: _____

Print Your Name: _____

Member Name: _____

Member Address:_____ SSN or ID #:_____

Please Print

<u>Mail or Fax Completed Forms to the Fund Administrator:</u>

3001 Metro Drive – Suite 500, Bloomington, MN 55425
Fax: 952-851-3521