



**Laborers Health and Welfare Trust Fund for Northern California**  
220 Campus Lane, Fairfield, CA 94534-1498 • Telephone: (707) 864-2800 • Toll Free: 1-(800) 244-4530

(3Z)

**Authorization For Use or Disclosure of Protected Health Information (PHI)**

**Section A: Must be completed for all authorizations**

I hereby authorize the use or disclosure of my Protected Health Information described below. I understand that this authorization is voluntary. I understand that the released information will no longer be protected by federal privacy regulations.

Participant Name: \_\_\_\_\_

S.S. Number: \_\_\_\_\_

Persons/organizations providing the information:  
\_\_\_\_\_  
\_\_\_\_\_

Persons/organizations receiving the information:  
\_\_\_\_\_  
\_\_\_\_\_

Check-off the applicable box(es) below for the type of information you authorize the Laborers Health and Welfare Trust Fund for Northern California, Health & Welfare Plans to disclose:

- All information about participant and family members including status of claims, eligibility and coverage information.
- Participant Information Only     Dependent Information Only     Claims Status Only     Coverage Information Only
- Other (please specify) \_\_\_\_\_  
\_\_\_\_\_

**Section B: Must be completed only if the Laborers Health and Welfare Trust Fund for Northern California, Health & Welfare Plans or its Business Associate has requested the authorization:**

1. The Laborers Health and Welfare Trust Fund for Northern California, Health & Welfare Plans must complete the following:
  - a. What is the purpose of the use or disclosure?  
\_\_\_\_\_
  - b. Will the organization requesting the authorization receive financial or in-kind compensation in exchange for using or disclosing the health information described above?      Yes       No
2. The participant or the participant's representative must read and initial the following statements:
  - a. I understand that my health care and the payment for my health care will not be affected if I do not sign this form.  
Initials: \_\_\_\_\_
  - b. I understand that I may see and copy the information described on this form if I ask for it, and that I get a copy of this form after I sign it.  
Initials: \_\_\_\_\_

**Section C: Must be completed for all authorizations:**

The participant or the participant's representative MUST READ, COMPLETE AND INITIAL the following statements:

1. I understand that this authorization will start on (indicate dates) \_\_\_\_/\_\_\_\_/\_\_\_\_ and expire on \_\_\_\_/\_\_\_\_/\_\_\_\_. Note: If you do not indicate the dates above, we will use the signed date below as start date and not revoke this authorization until you notify us in writing.      Initials: \_\_\_\_\_
2. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, but if I do it will not have any affect on any actions they taken before the organization received the revocation.  
Initials: \_\_\_\_\_

\_\_\_\_\_  
Signature of participant  
(Form documenting representative status must be completed before signing.)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed name of participant

• YOU MAY REFUSE TO SIGN THIS AUTHORIZATION •

