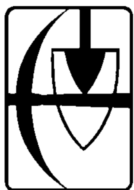

Laborers Health and Welfare Trust Fund for Northern California
220 Campus Lane, Fairfield, CA 94534-1498 • Telephone: (707) 864-2800 • Toll Free: 1-(800) 244-4530

(45)

Request for Confidential Communications of Protected Health Information (PHI)

I hereby request that all information relating to the Treatment described below, and to Payment for that Treatment be sent to me only at the following address:

Participant Name: ____________________ **Date of Birth:** ____________________

Address: ____________________ **Telephone:** ____________________

____

Participant Social Security Number: ____________________

Dates of Treatment: ____________________

Name and Address of Health Care Provider: ____________________

____

Describe how Payment for the above Treatment will be handled:

____

I affirm that disclosures of any part of the information relating to this Treatment to any other address will endanger me.

I understand that this request applies only to the Laborers Health and Welfare Trust Fund for Northern California, Health & Welfare Plans, and that I may request similar confidential communications from my health care providers.

I understand that the Laborers Health and Welfare Trust Fund for Northern California, Health & Welfare Plans must only accommodate reasonable requests. Accordingly, the Laborers Health and Welfare Trust Fund for Northern California, Health & Welfare Plans may deny this request if it determines the request to be unreasonable.

I understand that any false statement on this request constitutes fraud under federal law, and may be punishable as a criminal offense.

Signed: ____________________ Date: ____________________
Signature of Participant

If the request is approved, a copy of the request shall be sent to the appropriate Team Members and a copy of the request shall be maintained in the benefit file of the participant.