ILWU-PMA WELFARE PLAN
1188 FRANKLIN STREET, SUITE 101 - SAN FRANCISCO, CA 94109
Telephone (415) 673-8500 ✳ FAX (415) 749-1400

AUTHORIZATION for USE or DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

Name:_____ **Date:**_____

Local/Reg. Number:_____ **Telephone Number:**_____

As required by the Health Information Portability and Accountability Act of 1996 (HIPAA) and California law, the Benefit Plans office may not use or disclose your individually identifiable health information except as provided in our Notice of Privacy Practices without your authorization. Your completion of this form means that you are giving permission for the uses and disclosure described below. Please review and complete this form carefully. It may be invalid if not fully completed. You may wish to ask the person or entity you want to receive your information to complete the sections detailing the information to be released and the purposes for the disclosure.

I hereby authorize the use and/or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary

1. Person(s) or organization authorized to disclose the health information:

   _____

2. Person(s) or organization authorized to receive the health information:

   _____

   _____

3. Description of health information that may be used/disclosed (check ***only*** *one box)*:

   ❑ Any and all health information other than psychotherapy notes may be released, including, but not limited to, mental health records protected by the Lanterman-Petris-Short Act, drug and/or alcohol abuse records and/or HIV test results, if any, except as specifically provided below:

   _____

   _____

   ❑ All psychotherapy notes may be released, except as specifically provided below:

   _____

   _____

(over)

4. The information may be used only for the following purposes (if you do not want to explain the purpose, write "At the request of the individual"):

_____

_____

_____

5. I understand that although federal law does not protect health information which is disclosed to someone other than another health care provider, health plan or health care clearinghouse, under California law all recipients of health care information are prohibited from re-disclosing it except as specifically required or permitted by law.

7. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to enroll in a health plan, obtain health care treatment or payment or my eligibility for benefits.

8. I understand that I may revoke this authorization at any time by providing written notice to ILWU-PMA Welfare Plan, HIPAA Privacy Officer, 1188 Franklin Street, Suite 101, San Francisco, CA 94109. I understand that my revocation will not affect any actions already taken in reliance on this authorization.

9. I understand I may inspect or copy any information to be used or disclosed under this authorization.

10. This authorization is effective now and will remain in effect until

_____.
(Expiration event or date)

_____ _____
Signature of Individual (or Legal Representative) **Date**

_____
(Print) Individual's Name

_____ _____
(Print) Name of Legal Representative (if applicable) **Relationship to Individual**