AUTOMOBILE MECHANICS' LOCAL 701 UNION AND INDUSTRY WELFARE FUND

500 West Plainfield Road ~ Suite 203 ~ Countryside, IL 60525
Telephone: (708) 482-0110 ~ Toll Free: (800) 704-6270 ~ Fax: (708) 482-9140

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION
APPOINTMENT OF REPRESENTATIVE

Patient/Member Identification (person whose information will be released)

Name – Last, First, MI		ID Number
Street Address		
City	State	Zip Code
Birth Date	Phone Number	

I understand that this authorization will allow the Automobile Mechanics' Local 701 Union and Industry Welfare Fund to use or disclose the protected health information described below:

☐ Any and all protected health information the Automobile Mechanics' Local 701 Union and Industry Welfare Fund maintains including eligibility, benefits and benefit payments. This authorization also includes protected health information involving mental health, substance abuse, HIV and sexually transmitted or "communicable" diseases. Cross out any item you do not authorize for release.

☐ Protected health information about treatment for the following condition or injury:

_____

☐ Protected health information about treatment for the following provider of service:

_____

☐ Other. Please specify and include dates:

_____

This information can be disclosed to, and used by, the following people or organizations:

Name – Last, First, MI		Birth Date
Relationship to Patient (Spouse, Parent, Sibling, etc.)		
Street Address		
City	State	Zip Code

Name – Last, First, MI		Birth Date
Relationship to Patient (Spouse, Parent, Sibling, etc.)		
Street Address		
City	State	Zip Code

This information is being disclosed to allow the person(s) named above to assist me with my Automobile Mechanics' Local 701 Union and Industry Welfare Fund benefits or for the following purpose:

_____

This authorization shall become effective immediately and shall remain in effect until _____
(provide specific date or event)

(continued on reverse side)

- I understand that I have the right to revoke this authorization at any time by sending written notice to the Automobile Mechanics' Local 701 Union and Industry Welfare Fund. I further understand that the revocation is effective only after it is received at the Welfare Fund Office and that any use or disclosure made prior to the revocation will not be affected by the revocation.
- I understand that I am under no obligation to sign this authorization form. I acknowledge that I am voluntarily signing this form to release my protected health information to the party I have designated.
- I understand that eligibility for benefits is not conditioned on this authorization form.
- I understand that after my protected health information is disclosed pursuant to this authorization it could be disclosed by the recipient and the information may not be protected by federal privacy regulations.
- I understand that I am entitled to receive a copy of this authorization.
- I understand that a photocopy or facsimile of this signed authorization form shall be considered as valid as an original signed copy.
- I understand that if I am signing on behalf of a minor child, this authorization will expire upon the child reaching the age of 18 unless there is proof of legal guardianship.

Signature _____ Date _____

If you are signing as a Power of Attorney, Legal Guardian, Executor or Administrator complete the following and attach a copy of the Legal documents.

Personal Representative's Name _____ Relationship to Individual _____

Personal Representative's Address _____ City _____ State _____ Zip _____

Personal Representative's Area Code & Telephone Number _____

If you need assistance completing the form, please contact the Automobile Mechanics' Local 701 Union and Industry Welfare Fund Office at 708.482.0110 or 800.704.6270.