United Food and Commercial Workers Union Local 1529
And Employers Health and Welfare Plan and Trust

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Policy Holder's Name:________________________________ Policy Holder's ID or SSN:_____________________

Authorizing Party (Print Name of Person Completing Authorization):______________________________

IMPORTANT! Without this form on file, completed by you we cannot disclose any of your personal health information (PHI) to any party.

The undersigned (or his or her Personal Representative identified below), hereby authorizes the use or disclosure of my health information or the health information of my minor dependent child (identified below) as described in this authorization. Name specific person/organization authorized to provide information: **ACST, Inc. on behalf of UFCW and Employers H&W Plan and Trust**

Name specific person/organization **authorized to receive** and use this information; (You must list each person by name. In example, possible persons would include your spouse, parent, employer, attorney).

Authorized Person (s)	Relationship (spouse/employer/attorney/parent…)

INFORMATION TYPES: INITIAL below to indicate the information to be disclosed:

___Provider/Facility Name
___Explanation of Benefit Payment Details
___Diagnosis & Procedure Codes
___Nature of Injury or Illness
___Date Services Rendered
___Performed Procedure
___Lack of Claim Payment
___Benefit Eligibility
___Medical Records (If applicable)

___Other, please list if applicable: ____

DURATION: This authorization shall become effective immediately and shall remain in effect until _____/______/______.
(Must be valid date ex: 12/31/2030)

OR Initial Box for the date to be UPON TERMINATION OF ENROLLMENT IN THIS HEALTH PLAN

REVOCATION: I understand that I have the right to revoke this authorization at any time by notifying ACST, Inc. in writing. I understand that the revocation is only effective after it is received and logged by ACST, Inc. I understand that any use or disclosure made prior to the revocation under this authorization will not be affected by a revocation. I understand that after this information has been disclosed, federal law might not protect it and the recipient might disclose it again. I understand that I am entitled to receive a copy of this authorization, a copy shall be considered as valid as the original.

Signature of Individual ___________________________Date_____/______/________.
Name of Minor Dependent, if applicable________________ __________________

Name of *Personal Representative, if applicable________________ __________________
Signature of Personal Representative________________________________Date_____/______/______.

*If a Personal Representative executes this form, that representative warrants that he/she has the authority to sign the form and a copy of the written document that legally authorizes them to act in your behalf must be attached to this form.

AUTHORIZATION 2017-HIPAA

Without a valid Authorization, none of your Protected Health Information can be released to anyone outside of a Covered Entity, not even to a spouse. NO EXCEPTIONS.