San Francisco Electrical Workers Health & Welfare Trust

PARTICIPANT AUTHORIZATION FORM

[Authorization for psychotherapy notes must be made to "Pacificare Behavioural" and follow their procedures for authorization.]

Participant Name: _____ Birth Date: _____/_____/____
Date

Address: _____

_____

_____

Home Telephone Number: _____ E-mail: _____

Work Telephone Number: _____

Participant Social Security Number: _____ _____

By signing this authorization form I authorize the San Francisco Electrical Workers Health and Welfare Plan (Health Plan) to use and/or disclose my health information (information that constitutes protected health information as defined in the Privacy Rule of the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996) in the manner deemed necessary by the Health Plan in compliance with applicable law. I understand that I am under no obligation to sign this form. The Health Plan may not condition treatment, payment, enrollment in the health plan or eligibility for health care benefits on my signing this authorization, except as follows:

> A health plan may condition enrollment in the health plan or eligibility for benefits on this authorization if I am not yet enrolled in the health plan. The purpose of this authorization is to allow the health plan to obtain the information it needs to make an eligibility, enrollment, underwriting or risk rating determination and psychotherapy notes are not requested.

I have signed this form voluntarily to document my wishes regarding the use and/or disclosure of the health information described below in Section 1 of this form.

1. Description of Health Information I Authorize to be Used or Disclosed. The following is a specific description of the health information I authorize be used and/or disclosed: (Specify and provide a meaningful description.)

_____

_____

_____

2. Persons/Organizations Authorized to Use and/or Disclose My Health Information. I authorize the San Francisco Electrical Workers Health and Welfare Plan and designated staff pursuant to the Health Plan's privacy practices to use and/or disclose the health information described above in Section 1 of this form.

_____

3. Persons/Organizations Authorized to Receive and/or Use My Health Information. I authorize the following person(s) and/or organization(s) (or classes of persons and/or organizations) to receive my health information from the person(s) and/or organization(s) described in Section 2 above and to use or disclose such information for the purposes listed below in Section 4 of this form. I understand that if the person(s) and/or organization(s) listed below are not health care providers, health plans or health care clearinghouses subject to federal privacy standards, the health information disclosed pursuant to this authorization may no longer be protected by the federal privacy standards and such person(s) and/or organization(s) may re-disclose my health information without obtaining my authorization.

_____

_____

_____

4. Description of Each Purpose for the Requested Use and/or Disclosure. I authorize my health information to be used and/or disclosed for the following specific purposes:

_____

_____

_____

5. Your Rights with Respect to This Authorization.

5.1 Right to Revoke. I understand that I have the right to revoke this authorization at any time. I also understand that my revocation of this authorization must be in writing. Please mail your written request to revoke to: Privacy Official, 720 Market St., San Francisco, CA 94102 or Fax to (415) 263-3674. I am aware that my revocation will not be effective as to uses and/or disclosures of my health information that the person(s) and/or organization(s) identified in Sections 2 and 3 of this form have already made in reliance upon this authorization.

5.2 Right to Receive Copy of This Authorization. I understand that if I agree to sign this authorization, which I am not required to do, I must be provided with a signed copy of it.

[Use if applicable]

6. Disclosure of Direct or Indirect Remuneration Received By Any Person or Organization Authorized to Use or Disclose My Health Information. I understand that the following person(s) and/or organization(s) will be receiving direct or indirect remuneration in connection with the use or disclosure of my health information:

_____

_____

_____

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7. Expiration of Authorization. This authorization will expire (choose and complete one):

☐ On _____/_____/_____.
Date

☐ Upon the occurrence of the following event(s) related to my health care or to the purpose(s) for which I have authorized the use and/or disclosure of my health information described in Section 4 of this form:

_____

_____

_____

I, _____ (please print name), have had an opportunity to review and understand the contents of this form. By signing this form, I am confirming that it accurately reflects my wishes.

_____ _____/_____/_____
Participant Signature Date

If signed by a personal representative, complete the following:

Name of personal representative: _____
Relationship to participant or nature of authority (e.g., health care power of attorney, guardian, other statutory authorization): _____
Address: _____

_____

_____
Home Telephone Number: _____ E-mail: _____
Work Telephone Number: _____

_____ _____/_____/_____
Signature of Personal Representative Date