

**CENTRAL NEW YORK LABORERS' HEALTH AND WELFARE FUND**  
**7051 Fly Road, East Syracuse, New York 13057**

**AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION**  
**IF YOU DO NOT FILL OUT THIS FORM COMPLETELY AND DO NOT PROVIDE ALL OF THE**  
**REQUESTED INFORMATION, WE WILL NOT HONOR YOUR AUTHORIZATION**

Participant/Patient Name: \_\_\_\_\_  
Participant/Patient Address: \_\_\_\_\_

SS Number: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_

**I hereby authorize the Central New York Laborers' Health and Welfare Fund to disclose and discuss my individually identified health information (Protected Health Information or PHI) as described below.** I understand that after the information is disclosed, it may no longer be protected by the Federal Privacy Regulations and the recipient might re-disclose it.

Name and Address of Persons/Organizations authorized to receive the information:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

.....  
If you would like the Fund to disclose and discuss the following information to the persons/organizations identified above, please initial or check the applicable items:

- |  |   |
|--|---|
| 1. Enrollment or disenrollment information _____   | 10. Nature of treatment _____   |
| 2. Eligibility _____   | 11. Dates of service _____  |
| 3. Amount of contributions needed for coverage _____   | 12. Medical diagnosis/prognosis _____   |
| 4. Benefits available under Fund _____   | 13. Copies of all medical records concerning any physical or mental health conditions _____   |
| 5. Benefits received from Fund _____   | 14. Copies of medical records concerning any physical health conditions _____   |
| 6. Payment history, including coordination of benefits, subrogation and reimbursement issues _____     | 15. Copies of medical records concerning any mental health condition _____  |
| 7. Your address, date of birth, marital status, dependant information and social security number _____ | 16. There are no restrictions of on the type of information that may be disclosed and discussed with the person(s)/organization(s) designated above _____ |
| 8. Status of claims, including appeals and payment disputes _____                                      |   |
| 9. Name and address of medical provider _____  |   |

If you would like the Fund to only disclose copies of and discuss certain information, medical conditions or records, please identify that information, medical conditions and/or records:

\_\_\_\_\_  
\_\_\_\_\_

Purpose of the request: (If you do not wish to state a purpose, please state, "At My Request"):

\_\_\_\_\_  
\_\_\_\_\_

This authorization will expire on \_\_\_\_\_. (Please provide specific date or specific even, such as loss of eligibility)

.....  
The participant/patient or the participant's/patient's representative must read and initial the following statement:

I understand that: this authorization is voluntary and that I have the right to refuse to sign this authorization; I am entitled to receive a copy of this authorization; I have the right to revoke this authorization at any time by notifying the Fund Office in writing; the revocation is only effective after it is received by the Fund Office and it will not effect any actions taken by the Fund Office base on the authorization and prior to receipt of the revocation and the person/organization authorized to receive the information may not treat it as confidential and may re-disclose it.

Initials: \_\_\_\_\_

\_\_\_\_\_  
Signature of participant/patient  
(Form MUST be completed before signing)

\_\_\_\_\_  
Date:

**OR, if Signed by a Personal Representative of the Participant/Patient, the  
Personal Representative must Complete and Execute Below**

Print name of participant's/patient's personal representative: \_\_\_\_\_

Relationship to the participant/patient: \_\_\_\_\_

Basis of authority to act for participant/patient (provide copy of any documentation establishing such authority):  
\_\_\_\_\_

\_\_\_\_\_  
Signature of participant's/patient's personal representative:  
(Forms MUST be completed before signing)

\_\_\_\_\_  
Date: