Important Privacy Information

Government Regulations require UA Local 357 Health and Welfare Plan to provide you with the enclosed "Notice of Privacy Practices". Please read this notice carefully.

Under the privacy law UA Local 357 Health and Welfare Plan can provide your health information to your family members only if you sign a written authorization naming the family members who are permitted to receive this information. If you authorize the Plan to use or disclose your health information, you may revoke that authorization in writing at any time.

If you completed an "Authorization for Release of Protected Heath Information" in the past it will no longer be effective beginning April 14, 2021. The UA Local 357 Health and Welfare Insurance Plan are required to have you complete a new authorization every three years.

Enclosed is "Authorization for Release of Protected Health Information" form which should be completed by you, your spouse and your dependents over the age of 18 if you want us to discuss your health information with your family members. A pre-addressed envelope is enclosed for your convenience.

The UA Local 357 Health and Welfare Plan Benefit Office will not release claims, payment or eligibility information to your spouse or family members unless you complete and return the enclosed authorization form.

If you have any questions concerning the above notices please contact the Benefit Office at 1-888-281-3461

THE UNITED ASSOCIATION OF JOURNEYMEN PLUMBERS AND JOURNEYMEN PIPEFITTERS AND STEAMFITTERS LOCAL UNION 357 HIPAA AUTHORIZATION FORM

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH CARE INFORMATION

Member Name _____ SS#: _____

Spouse Name _____ SS#: _____

Dependent over age18: _____ SS#: _____

1. I authorize UA Local 357 Health and Welfare Insurance Plan, to disclose claims, payment, eligibility and other health information at the request of my spouse or family members as identified below (Member complete section **A**, spouse complete section **B** and dependents over 18 complete section **C**).
2. I understand that the health information that is disclosed pursuant to this authorization may be redisclosed by the persons that I identified below and might lose its protected status.
3. I understand that this authorization will expire April 14, 2024 unless I revoke it sooner.
4. I understand that I may revoke this authorization at any time, except to the extent that it has already been relied upon, by giving written notice to:

UA Local 357 Health and Welfare Plan
30700 Telegraph Rd. Ste. 2400
Bingham Farms, MI 48025

You have a right to receive a copy of this authorization. Upon signing this form please keep a copy of this authorization for your files or request a copy by writing to the above.

A. Member (List person(s) who you give authorization to receive your health care information)

Name:	Relationship:
Name:	Relationship:

I 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.

Member Signature: _____ Date: _____

B. **Spouse** (List person(s) who you give authorization to receive your health care information)

Name:	Relationship:
Name:	Relationship:

I 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.

Spouse Signature: _____ Date: _____

C. Dependent over age 18
(List person(s) who you give authorization to receive your health care information)

Name:	Relationship:
Name:	Relationship:

I 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.

Dependent Signature: _____ Date: _____

D. Personal Representative (If signed by a personal representative, complete the information under this section)

Name of personal representative: _____

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

Personal Representative Signature: _____ Date: _____

INSTRUCTIONS

1. Fill in your name and social security number at the top of page 1.
2. If you are married and you want to give your spouse authority to inquire about your health information, please enter his/her name and relationship (spouse).
3. If you are not married or you want to give someone other than your spouse authority to inquire about your health information, please enter his/her name and relationship (mother, father, friend, etc.)
4. Dependents over the age of 18 - If you want to give your parents authority to inquire about your health information, please enter their name and relationship (mother, father, etc.)
5. Please sign and date the form where indicated under sections A, B and C.
6. If you are signing as a personal representative please include copies of the appropriate documentation.

The Kalamazoo Plumbers & Pipefitters UA Local 357 Health and Welfare Insurance Plan office will not release claims, payment, eligibility and other health information to your spouse or family members unless you complete and return this form.