# Northern Minnesota-Wisconsin Area Retail Food Heath & Welfare Fund

## Authorization for Release of Protected Health Information (PHI) By the Health Fund

***You MUST complete all of the information requested in this form for your authorization to be valid.***

I authorize the Fund the use of disclosure of my Protected Health Information (PHI) as described in this authorization. I understand the Fund may not condition my treatment, payment, enrollment or eligibility for benefits on whether or not I give the authorization listed in this form.

(1) **The Plan can release PHI to:** The Fund, its agents or subcontractors ("Business Associates") is authorized to release the PHI described below to the following person, class of persons, or organization:

□ My spouse □ My Union

□ My parents □ My Employer

□ Other (Print Name or Position): _____

(2) **The information that may be used or released is:**

□ Medical information held by the Fund from the following doctor, clinic, or hospital:

_____

□ Information held by the Fund concerning my eligibility, claims decisions and payments.

□ Other. Please specify below.

_____

_____

(3) **Right to revoke:** I understand that I have the right to revoke this authorization at any time by notifying the Fund's Contact Person in writing at the address listed at the top of this Form. I understand that the revocation is only effective after it is received and logged by the Fund. I understand that any use or disclosure made prior to the revocation under this authorization will not be affected by a revocation.

(4) **Re-Release of Information:** I understand that after this information is released, federal law might not protect it and the recipient might re-release it. I also understand and agree to hold the Fund and any of its agents and subcontractors harmless if the information is re-released.

(5) **Copy:** I understand that the Fund will give me a copy of this authorization if requested.

(6) **THE AUTHORIZATION WILL EXPIRE ON THE DATE ON WHICH YOUR ELIGIBILITY UNDER THE PLAN TERMINATES UNLESS YOU SPECIFY ANOTHER DATE OR TERMINATION EVENT BELOW.**

□ Other: _____

Your Signature: _____ Date: _____

Print Your Name: _____

If you are covered under the Fund as a Dependent, please print the name and social security or medical ID number of the covered employee:

Name: _____ SSN/ID #: _____

**Mail or Fax Completed Forms to the Fund Administrator:**

2002 London Road – Suite 300, Duluth, MN 55812
Fax: 218-728-4773