Northern California Plasterers Trust Funds
Health & Welfare Trust Fund, Pension Plan and Plasterers Local 66 Supplemental Pension Trust
4160 Dublin Boulevard, Suite 400, Dublin, CA 94568-7756
Toll Free: 1-(844) 663-8121 * Fax: 1-(925) 833-7301
Email: plasterersinfo@hsba.com

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

PATIENT'S DATA		**INSURED'S DATA**	
LAST NAME	FIRST NAME	LAST NAME	FIRST NAME
SOCIAL SECURITY NUMBER	DATE OF BIRTH	SOCIAL SECURITY NUMBER	DATE OF BIRTH
ADDRESS		ADDRESS	
TELEPHONE #	EMAIL ADDRESS	TELEPHONE #	EMAIL ADDRESS

I HEREBY AUTHORIZE THE USE AND/OR DISCLOSURE OF THE INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION AS DESCRIBED BELOW. I UNDERSTAND THAT THIS AUTHORIZATION IS VOLUNTARY. I ALSO UNDERSTAND THAT IF THE PERSON OR ORGANIZATION AUTHORIZED TO RECEIVE THE INFORMATION IS NOT A HEALTH PLAN OR HEALTH CARE PROVIDER, THE RELEASED INFORMATION MAY BE RE-DISCLOSED AND MAY NO LONGER BE PROTECTED BY FEDERAL PRIVACY REGULATIONS.

1. PERSON/ORGANIZATION (OR CLASS OF PERSONS) AUTHORIZED *TO DISCLOSE* PERSONAL HEALTH INFORMATION:
Health Fund and Plan Administrator

2. PERSON/ORGANIZATION (OR CLASS OF PERSONS) AUTHORIZED *TO RECEIVE* PROTECTED HEALTH INFORMATION (check as many as apply)

☐ Spouse (provide name) _____ ☐ Local 300 Business Manager/Agents

☐ Employer/HR Person: _____ ☐ Other _____
(provide name) (please specify)

3. DESCRIPTION OF PROTECTED HEALTH INFORMATION THAT MAY BE USED/DISCLOSED:

☐ All Protected Health Information (PHI)

☐ Only the following PHI (please be specific):

4. PURPOSE OF USE/DISCLOSURE

☐ At the request of the authorized entity.

☐ Other (please specify)

5. THIS AUTHORIZATION IS EFFECTIVE UNTIL (check one):

☐ Revoked by Patient ☐ Specific Date: _____

6. I UNDERSTAND THAT I MAY REFUSE TO SIGN THIS AUTHORIZATION AND THAT MY REFUSAL TO SIGN WILL NOT AFFECT MY ABILITY TO ENROLL IN A HEALTH PLAN, OBTAIN HEALTH CARE TREATMENT OR PAYMENT OR ELIGIBILITY FOR BENEFITS. I FURTHER UNDERSTAND THAT I MAY ESTABLISH AN EXPIRATION DATE OR REVOKE THIS AUTHORIZATION AT ANY TIME BY PROVIDING WRITTEN NOTICE TO: PRIVACY OFFICER, NORTHERN CALIFORNIA PLASTERERS HEALTH & WELFARE PLAN, C/O ALLIED ADMINISTRATORS, P.O. BOX 2500, SAN FRANCISCO, CA 94126.

7. MY REVOCATION WILL NOT AFFECT ANY ACTIONS ALREADY TAKEN IN RELIANCE ON THIS AUTHORIZATION, AND I MAY INSPECT OR COPY ANY INFORMATION TO BE USED OR DISCLOSED UNDER THIS AUTHORIZATION. A COPY OF THIS FORM, INCLUDING A FACSIMILE ORIGINAL SHALL BE TREATED AS AN ORIGINAL.

A COPY OF THIS FORM MUST BE GIVEN TO THE INDIVIDUAL.

_____ _____
Patient's Signature (or Signature of Legal Representative) Date

_____
Patient's Name (please print)

- FOR INTERNAL OFFICE USE ONLY -

☐ Copy Patient ☐ Copy LU 300 (if designated) ☐ Doc HBS