Benefit Services
SERVING LOCAL UNION 725 & MCASF
15800 Pines Blvd, Suite 201, Pembroke Pines, FL 33027
info@725benefits.org | 754.777.7735

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Member/Retiree Section

I _____ authorize the Health and Welfare Plan (the "Plan"), and its business associates, to disclose claims, payment, eligibility and other related health information including mental health about me to the following persons (select 1-2 persons if desired), at the request of such persons:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I understand that this authorization will expire upon termination of my enrollment in the Plan, unless I revoke it sooner. I understand that I have the right to revoke it at any time, except to the extent that is has already been relied upon. I understand that if I decide to revoke this authorization, I must give notice of my decision in writing and send it to:

HIPAA Contact Person
MCASF Local Union 725 Health & Welfare Trust Fund
c/o Benefit Services
15800 Pines Blvd., Suite 201
Pembroke Pines, FL 33027

I understand that my health information that is disclosed pursuant to this authorization may be redisclosed by the persons I have identified above, and the Plan cannot prevent or protect such redisclosures, AND I understand that I am not required to sign this form to receive my health care benefits (enrollment, treatment, or payment).

Signature of Member: _____ **Date Signed:** _____

-OR- ☐ I do not want my Health Information including mental health released to anyone but myself.

Signature of Member: _____ **Date Signed:** _____

Spouse Section

I, the spouse (Name, please print) _____, Social Security Number _____ have also read, understand and authorize the Plan to disclose claims, payment, eligibility, and other related health information including any mental health information about me to the following persons (select 1-2 persons if desired) for the reasons and with the explanations listed above, at the request of such persons:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Signature of Spouse: _____ **Date Signed:** _____

-OR- ☐ I do not want my Health Information including mental health released to anyone but myself.

Signature of Spouse: _____ **Date Signed:** _____

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Dependent(s) Over the Age of 18 Section

I, the dependent child(ren) over age 18 (Name, please print) _____, Social Security Number: _____ have also read, understand, and authorize the Plan to disclose claims, payment, eligibility, and other related health information including mental health about me to the following persons (select 1-2 persons if desired) for the reasons and with the explanations listed above, at the request of such persons:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Signature of Dependent: _____ **Date Signed:** _____

-OR- ☐ I do not want my Health Information including mental health released to anyone but myself.

Signature of Dependent: _____ **Date Signed:** _____

I, the dependent child(ren) over age 18 (Name, please print) _____, Social Security Number: _____ have also read, understand, and authorize the Plan to disclose claims, payment, eligibility, and other related health information including mental health about me to the following persons (select 1-2 persons if desired) for the reasons and with the explanations listed above, at the request of such persons:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Signature of Dependent: _____ **Date Signed:** _____

-OR- ☐ I do not want my Health Information including mental health released to anyone but myself.

Signature of Dependent: _____ **Date Signed:** _____

NOTE: If there is more dependent(s) over the age of 18, please copy, complete and sign the appropriate number of additional Authorization Forms and return to the Benefit Office.