EWBTF
Electrical Workers Benefit Trust Fund

T 317.923.4577 | **F** 317.923.7633 | **E** info@ewbtf.org

1828 North Meridian Street – Suite 103, Indianapolis, IN 46202

HIPAA AUTHORIZATION FORM

The HIPAA Authorization is an **optional** form. If you are over the age 18 and would like the Benefits Office to discuss your personal health information (PHI) with someone other than yourself, this form must be completed and returned. PHI is individually identifiable information created or received by the Plan that relates to: your past, present or future physical or mental health condition; the providers of health care to you; or the past, present or future payment for the provision of health care to you. Any disclosure is at the request of the individual.

PARTICIPANT SECTION	
Participant Name:	**SSN:**
Cell Phone:	**Email Address:**
YOUR INFORMATION	
Your Name:	**Relationship to Participant:**
Phone Number:	**Email Address:**

DISCLOSURE INFORMATION			
Person We May Speak To	**Limit of Info We Can Share** *(Specific, Unlimited)*	**Info to Disclose** *(General, Specific)*	**Expiration Date of Authorization**

EXAMPLE

PARTICIPANT SECTION	
Participant's Name: John Doe	**SSN:** 111-11-1111
Cell Phone: 444-444-4444	**Email Address:** johndoe481@gmail.com
YOUR INFORMATION	
Your Name: Jane Doe	**Relationship to Participant:** Wife
Phone Number: 444-444-4444	**Email Address:** janedoe@yahoo.com

DISCLOSURE INFORMATION			
Person We May Speak To	**Limit of Info We Can Share** *(Specific, Unlimited)*	**Info to Disclose** *(General, Specific)*	**Expiration Date of Authorization**
John Doe (Husband)	Unlimited	General	End of eligibility in plan
Jack Doe (Son)	Specific	Info about claims on 4/4/2019	01/01/2025

1. Jane is giving unlimited access to her husband. EWBTF can discuss any information pertaining to Jane's medical history. EWBTF can discuss info as long as Jane is covered by the Plan
2. Jane is giving specific access to her son. EWBTF can ONLY discuss information pertaining to Jane's medical claims on 4/4/2019. After 1/1/2025, EWBTF can no longer discuss any information regarding Jane.

PLEASE READ CAREFULLY AND SIGN BELOW

The undersigned acknowledges that once PHI is received by individuals that are not covered by federal privacy regulations; the PHI may be re-disclosed and no longer protected by the federal privacy regulations. The undersigned further understands that this authorization may be revoked prospectively at any time by providing written notification to the Plan's Privacy Officer, except to the extent EWBT has taken action in reliance on the authorization. The fund may not condition treatment, payment, enrollment, or eligibility for benefits on your execution of this authorization. **Please note that each individual (over 18) covered by the Plan who wishes to authorize release of his/her PHI must fill out his/her own HIPAA authorization form.**

Signature:	**Date:**