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 of 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 conditions; 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's name: _____ SSN/ Member ID: _____

Person authorizing release: _____ Relationship to Participant: _____

Phone: _____ Email: _____

I hereby authorize the disclosure of information by EWBTF to Release my information to:

Name: _____ Relationship: _____ DOB: _____
Limit info we can share: ☐ Unlimited or ☐ Specific
Explain Specific: _____
Info to Disclose: ☐ General or ☐ Specific
Explain Specific: _____
Expiration Date of Authorization: ☐ End of Eligibility in Plan or ☐ Other _____

Name: _____ Relationship: _____ DOB: _____
Limit info we can share: ☐ Unlimited or ☐ Specific
Explain Specific_____
Info to Disclose: ☐ General or ☐ Specific
Explain Specific:_____
Expiration Date of Authorization: ☐ End of Eligibility in Plan or ☐ Other _____

Name: _____ Relationship: _____ DOB: _____
Limit info we can share: ☐ Unlimited or ☐ Specific
Explain Specific_____
Info to Disclose: ☐ General or ☐ Specific
Explain Specific:_____
Expiration Date of Authorization: ☐ End of Eligibility in Plan or ☐ Other _____

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 EWBTF 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:** _____