SOUTHERN CALIFORNIA PIPE TRADES
HEALTH & WELFARE FUND and
PENSIONERS & SURVIVING SPOUSES HEALTH FUND
501 Shatto Place, 5th Floor, Los Angeles, CA 90020 | (800) 595-7473 (213) 385-6161 | Fax (213) 487-3640 | www.scptac.org

# AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

If you want to authorize the Southern California Pipe Trades Health & Welfare and/or Pensioners & Surviving Spouses Health Fund ("Fund") to disclose your, or your minor child's, Protected Health Information ("PHI") to someone other than you, you must complete this Authorization Form and return it to the Fund Office. PHI is information that is created, received, transmitted or stored by the Fund which relates to your past, present, or future physical or mental health, health care, or payment for health care, and either identifies you or provides a reasonable basis for identifying you. Except as permitted by law, the Fund may not use or disclose PHI to persons other than those you specify on this form. This form is not needed if you are requesting your own PHI from the Fund. Additional information regarding PHI can be found in your Summary Plan Description.

## PART 1 Patient Information

| | | | |
|---|---|---|---|
| NAME | | | |
| BLUE SHIELD OF CALIFORNIA ID | T500 | OR, SSN | *Only last 4 digits required* - - |
| DATE OF BIRTH | *mm/dd/yy* / / | | |
| ADDRESS | *Street, City, State, ZIP* | | |
| PHONE | ( ) - | | |

## PART 2 Authorized Person

**RELEASE MY PHI TO:**

| | |
|---|---|
| NAME | |
| ADDRESS | *Street, City, State, ZIP* |

## PART 3 Effective Period

**I want this Authorization to be valid:**

| | |
|---|---|
| ☐ For as long as the patient is eligible for benefits under the Plan | ☐ Until the patient submits a Cancellation of Authorization Form |

You may cancel this authorization at any time, no matter which option you select above, by submitting to the Fund Office a properly completed Cancellation of Authorization Form.

## PART 4 Description of Information

**I authorize the Fund to disclose the following Protected Health Information (PHI):**

☐ ALL PHI (including mental health, genetic testing, and substance abuse information, if any)

☐ Only the following PHI: _____

## PART 5 Purpose of Disclosure

**The purpose for which my PHI may be disclosed is as follows:**

☐ For any purpose (including payment, eligibility, preauthorization, health care claims or appeals, coordination or benefits, premiums and co-payments, subrogation and reimbursement)

☐ Only the following purpose: _____

## PART 6 Authorization

**I authorize the Fund to disclose my Protected Health Information (PHI), in written, electronic, or oral form, to the person(s) identified in Part 2.**

I understand that:

- I have the right to revoke this form at any time by submitting a Cancellation of Authorization Form to the Fund Office
- The person I am authorizing to receive my PHI may not be required to treat this information as confidential

| **PATIENT SIGNATURE** *(parent or legal guardian, if minor child)* | **PRINT NAME** | **DATE** |
|---|---|---|
| **X** | | |