SOUTHERN CALIFORNIA PIPE TRADES ADMINISTRATIVE CORPORATION
501 Shatto Place, Suite 500, Los Angeles, CA 90020 | (800) 595-7473 (213) 385-6161 | Fax (213) 386-0418 | Email info@scptac.org | www.scptac.org

AUTHORIZATION TO DISCLOSE CONFIDENTIAL INFORMATION

This Authorization Form may be used to authorize the Southern California Pipe Trades Administrative Corporation ("Fund Office") to disclose information regarding any of the six Southern California Pipe Trades trust funds administered by the Fund Office.

If you want to authorize the Fund Office 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 Office 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 Office 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 Office. Additional information regarding PHI can be found in your Summary Plan Description.

If this form pertains to non-PHI only, skip Parts 2, 4, and 7. If this form pertains to PHI only, skip Part 5.

Part 1 Participant Information

NAME			
DATE OF BIRTH	mm/dd/yyyy / /	SOCIAL SECURITY NUMBER	Only last four SSN digits required - -
ADDRESS	Street	City	State ZIP
PHONE	( ) -	EMAIL	

Part 2 Patient for Health Information Disclosure (if different from PART 1)

COMPLETE THIS SECTION ONLY FOR PHI DISCLOSURE

NAME		RELATIONSHIP TO PARTICIPANT	
DATE OF BIRTH	mm/dd/yyyy / /	SOCIAL SECURITY NUMBER	Only last four SSN digits required - -
ADDRESS	Street	City	State ZIP

Part 3 Authorized Person

RELEASE MY PHI AND/OR OTHER FUND(S) INFORMATION TO:

NAME			
ADDRESS	Street	City	State ZIP

Part 4 Description of Health Information Authorized

I AUTHORIZE THE FUND OFFICE TO DISCLOSE THE FOLLOWING PROTECTED HEALTH INFORMATION (PHI):

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

☐ ALL PHI, EXCEPT (please specify):

☐ ONLY the following PHI (please specify):

Part 5 Description of Non-Health Information Authorized

I AUTHORIZE THE FUND OFFICE TO DISCLOSE NON-PHI INFORMATION (INCLUDING ACCOUNT BALANCE DETAILS) FOR THE FOLLOWING FUND(S):

☐ ALL Funds

☐ ONLY the following Funds: ☐ Vacation & Holiday Fund ☐ Defined Contribution Fund ☐ Retirement Fund ☐ Christmas Bonus Fund

Part 6 Effective Period

I WANT THIS AUTHORIZATION TO BE VALID:

☐ INDEFINITELY from the signature date in Part 8 below	☐ UNTIL the following date:

Note: 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 available on www.scptac.org.

Part 7 Purpose of Health Information Disclosure

THE PURPOSE FOR WHICH MY PHI INFORMATION MAY BE DISCLOSED IS AS FOLLOWS:

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

☐ ONLY the following purpose (be specific):

Part 8 Authorization

I AUTHORIZE THE FUND OFFICE TO DISCLOSE MY INFORMATION, IN WRITTEN, ELECTRONIC, OR ORAL FORM, TO THE PERSON IDENTIFIED IN PART 3.

I understand that:

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

PARTICIPANT OR PATIENT SIGNATURE Parent or Legal Guardian, if Minor Child, or Personal Representative* X	**PRINT NAME**	**DATE** / /

*If you are acting as the Personal Representative of the individual whose information is to be disclosed, you must provide proof of your authority to act for that individual.