ST. PAUL ELECTRICAL WORKERS HEALTH PLAN
1330 Conway Street • Suite 130
St. Paul, Minnesota 55106
(952) 851-5949

Dear Member,

Please fill out the enclosed PHI form giving us permission to speak to whomever you designate. Without this, we cannot give out information regarding your medical claims, your deductible, address changes, etc. This form will need to be filled out by anyone over the age of 18.

HINT: In section 2 if you mark the first box we can speak to whomever you designate us to speak to about everything. If you mark box two than we need you to list the doctors, clinics and everything else that we can speak to the designated person about.

If you have any questions, please feel free to give us a call at 952-851-5949, Monday – Thursday 7:30am to 4:30 pm & Friday 7:30 am to 3:30 pm

Please Return:

Mail: (enclosed return envelope)

Fax: 651-776-9973 Atten:

Email: spewbenefits@wilson-mcshane.com

Thank you
St. Paul Electrical Worker's Benefit Office

GCC/IBT 152-C

St. Paul Electrical Workers Health Plan

Authorization for Release of Protected Health Information (PHI) By the Fund

*You **MUST** complete all of the information requested in this form for your authorization to be valid.*

I authorize the Plan the use of disclosure of my Protected Health Information (PHI) as described in this authorization. I understand the Plan may not condition my treatment, payment, enrollment or eligibility for benefits on whether or not I give the authorization listed in this form.

(1) **The Plan can release PHI to:** The Plan, its agents or subcontractors ("Business Associates") is authorized to release the PHI described below to the following person, class of persons, or organization:

□ My spouse ______________________ □ My Union ______________________

□ My parents ______________________ □ My Employer ______________________

□ Other (Print Name or Position): ____

(2) **The information that may be used or released is:**

□ Information held by the Plan concerning my eligibility, claims decisions and payments.

□ Medical information held by the Plan from the **following doctor, clinic, or hospital**:

____

□ Other. Please specify below.

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(3) **Right to revoke:** I understand that I have the right to revoke this authorization at any time by notifying the Plan's Contact Person in writing at the address listed at the top of this Form. I understand that the revocation is only in effect after it is received and logged by the Plan. I understand that any use or disclosure made prior to the revocation under this authorization will not be affected by a revocation.

(4) **Re-Release of Information:** I understand that after this information is released, federal law might not protect it and the recipient might re-release it I also understand and agree to hold the Plan and any of its agents and subcontractors harmless if the information is re-released.

(5) **Copy:** I understand that the Plan will give me a copy of this authorization

(6) **THE AUTHORIZATION WILL EXPIRE ON THE DATE ON WHICH YOUR ELIGIBILITY UNDER THE PLAN TERMINATES UNLESS YOU SPECIFY ANOTHER DATE OR TERMINATION EVENT BELOW.**

□ Other: ____

Your Signature:______________________________________Date: ____________________

Print Your Name: ____

Member Name: ____

Please Print

Member Address:______________________________________SSN or ID #:____________________

Mail or Fax Completed Forms to the Fund Administrator:

1330 Conway St, Ste 130
St. Paul, MN 55106
Fax: (651) 776-9973