SHEET METAL WORKERS' LOCAL #270 GROUP HEALTH PLAN

HIPAA Authorization Form*

Name: _____

Address: _____

1. ***Check one of the following:***

   ☐ I am a covered employee under the Plan.

   ☐ I am covered under the Plan as a spouse or dependent of: _____
   (print name of covered employee)

   ☐ Other (describe): _____

2. **I hereby authorize the use or disclosure of my protected health information ("PHI") maintained by the Plan as follows *(complete items a through d)*:**

   a. *Specific person (or class of persons) authorized to receive and use the information:*

      ☐ My Spouse, whose name is: _____

      ☐ My parents, whose names are: _____

      Other (name and relationship): _____

   b. *Specific description of the information to be used or disclosed (not including psychotherapy notes):*

      ☐ All information held by or on behalf of the Plan.

      ☐ All information relating to the following illness or injury: _____

      ☐ Other (describe): _____

   c. *Purpose(s) of the request (if Requestor wishes to state a purpose):*

      ☐ To assist me with any matter relating to my Plan coverage.

      ☐ Other (describe): _____

   d. *This authorization will expire on:*

      ☐ When my coverage under the Plan terminates.

      ☐ Other date or event (describe in relation to the individual or purpose): _____

3. **My Rights**: I understand that I have the right to revoke this authorization at any time by notifying the Plan's Privacy Official, in writing at 1863 North 105th East Avenue, Tulsa, OK 74116. I understand that any use or disclosure made prior to the Privacy Officer's receipt of a revocation under this authorization will not be affected by such revocation. I understand that after this information is disclosed, Federal law might not protect it and the recipient might redisclose the information without my authorization. I understand that I am entitled to receive a copy of this authorization. I understand that I am not required to sign this authorization in order to receive health care benefits (payment, treatment, eligibility or enrollment).

X _____ _____
Signature of Requestor Date

*This form must not be used for authorization of marketing or sale of PHI.