UAW RETIREE
Medical Benefits Trust

Personal Health Information Authorization Instructions & Form

Authorization Section Instructions

Authorization Section

1. On the first blank line provided, please insert the specific name of the individual being selected as the authorized representative(s). You can choose to select a class of Representatives, such "All Local 1 Benefit Representatives, Alternates," if applicable.

2. Please indicate in the appropriate box what type of PHI is being authorized for use or disclosure to your "Authorized Representative(s)." If it is "other," then in the additional space provided describe the type of PHI that may be used or disclosed, such as claims, enrollment, EOBs, historical appeal information, etc.

3. Please mark the box indicating the agreed purpose(s) of the use or disclosure of PHI. If the purpose is "other," identify the alternative purpose of the use or disclosure of PHI.

4. On the line provided, please list the expiration date of the authorization or check the appropriate box indicating whether the authorization expires at the resolution of the issue(s) identified on the reverse side of the form (i.e., Claim Inquiry/Appeal Form) or other event. If the response is "other," describe the subsequent event that terminates this authorization.

5. The individual who's PHI is being disclosed or his/her personal representative(s), must read the terms of this authorization form.

6. The individual who's PHI is being disclosed or his/her personal representative(s), must sign and date this authorization form.

Personal Representative

If a Personal Representative is completing the authorization form on behalf of the subscriber, please attach the appropriate documentation supporting the nature of the authority, such as:

- legal authority (i.e., power of attorney),
- parent or guardian or other individual acting in loco parentis, or
- written designation by the Subscriber

Written Revocation of an Authorization:

The subscriber must send the written revocation to the applicable Health Care Plan/Carrier to which the original authorization was given.

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Authorization

I_____(print name) authorize the use or disclosure of health information that could be used to identify me (called "Protected Health Information") as described below. Protected Health Information ("PHI") is any information that relates to: (1) My past, present or future physical or mental health or condition; (2) Health care I have received or will receive; and/or (3) Payment for health care I have received or will receive.

I am naming _____
as my Authorized Representative(s) to submit this claim information to my Health Care Plan/Carrier on my behalf and I authorize the Health Care Plan/ _____ (Carrier) to provide my Authorized Representative(s) with the PHI described herein.

I authorize the use or disclosure of the following PHI to my Authorized Representative(s): (Please check the appropriate box)

- ☐ PHI that is relevant to review of the claim(s) identified on the attached Claims Appeals/Inquiry Form
- ☐ Other (Please indicate specific PHI, for example: EOB statements, claims information, provider reports, etc.)

_____
_____
_____
_____

I agree that my PHI will only be used or disclosed for the following purpose(s): (Please check the appropriate box)

- ☐ To ONLY resolve the issue(s) identified on the attached Claims Appeals/Inquiry Form
- ☐ Other (Please describe the specific uses and disclosures)

_____
_____
_____

This authorization expires on the earlier of _____, 20_____ or the following event: (Please check the appropriate box)

- ☐ Resolution of the issue(s) identified on the attached Claims Appeals/Inquiry Form
- ☐ Other (Please Describe the Event that Terminates this Authorization)

_____
_____
_____

I understand that:

(1) PHI disclosed in reliance on this Authorization may be re-disclosed and may no longer be protected by the Health Insurance Portability and Accountability Act of 1996.
(2) I have the right to revoke this Authorization in writing at any time, except to the extent the Health Care Plan and/or _____(Carrier) has taken action in reliance upon this Authorization, by submitting a written request to the Carrier.
(3) This Authorization is voluntary and that I may refuse to sign this Authorization. My refusal to sign will not affect my eligibility for Plan benefits or my enrollment in or coverage under the Plan.

I have read and understand the above, and I agree to the terms of this Authorization, and I understand that the the disclosure is being made at my request.

_____ _____
Signature of Individual or their Personal Representative Date