Alaska Electrical Health & Welfare Fund
701 E Tudor, Suite 200
Anchorage, AK 99503
(907) 276-1246 • (800) 478-1246 • FAX (907) 278-7576
www.aetf.com

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Identify below, the individual whose protected health information will be disclosed:

Individual's Name	Individual's Social Security Number	Individual's Daytime Phone
Mailing Address	City	State / Zip Code
Participant's Name (If different than Individual's)	Participant's Social Security Number	Relationship to Participant

PURPOSE OF AUTHORIZATION

This Authorization is required for your Health Plan to release your health information to someone other than yourself or for purposes outside the Health Plan's normal operations (treatment, payment of claims or healthcare operations). The recipients of this Authorization will rely on it to disclose your health information. Please review it carefully.

STATEMENT OF RIGHTS REGARDING THIS AUTHORIZATION

General Rights. I understand I am not required to sign this form and that a Covered Entity receiving it cannot condition treatment, payment or eligibility on my decision to sign this form. I understand, however, that a health plan can condition enrollment in the Plan or eligibility for benefits on receiving an authorization if the purpose is to allow the health plan to obtain information it needs to make an eligibility, enrollment or underwriting decision and psychotherapy notes are not requested.

Right to Revoke. I understand that I have the right to revoke this authorization in writing except as to uses and/or disclosures already made in reliance on it. Authorization revocation forms can be obtained by contacting the Contact Person listed in my Health Plan's Privacy Notice.

Effect of Disclosure. I understand that if the persons to whom my health information is disclosed are not subject to the HIPAA Privacy Rule (i.e. are not a health plan, health care provider or health care clearinghouse), the disclosed health information may no longer be protected by the HIPAA Privacy Rule and may be redisclosed without my authorization.

Retention and Right to Copy. I understand that a Covered Entity which receives this Authorization must retain a copy and that I am required to receive a signed copy as well.

Provisions Related to Psychotherapy Notes. I understand that an Authorization is required for any use or disclosure of psychotherapy notes except in the limited situations dealing with treatment, training or defense of legal actions as defined in 45 CFR 164.508(a)(2).

NATURE OF DISCLOSURE BEING AUTHORIZED

The information requested in Questions 1 through 6 **must** be provided for this Authorization to be effective.

1. **Describe Health Information To Be Disclosed** Identify below what health information you authorize to be used or disclosed. The description should be specific such as "Information related to my knee surgery":

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2. **Describe the Purpose of the Disclosure**: List why the information is being disclosed. If you are initiating the request, you can simply list "At the request of the individual."

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3. **Identify Who Is Authorized to Disclose the Information:** Identify here who is authorized to make the disclosure. Be specific such as the "Administrative Office." Check each box which applies:

- ☐ Administrative Office
- ☐ Aetna (Utilization Review and Case Management)
- ☐ Caremark (Prescription Drug Manager)
- ☐ VSP (Vision Plan Manager)
- ☐ All of the Above
- ☐ Other: ____

4. **Identify Who Will Receive the Information:** List here persons or organizations you authorize to receive information such as "Mary Jones, my spouse" or "John Doe, my union representative."

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5. **Identify How To Provide Information:** Where and how should the information be disclosed? List address, e-mail, facsimile, etc. Please remember that the information being sent is your private health information.

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6. **Expiration Date of Authorization:** Indicate when your authorization will end. This can be a date (12/31/2015) or the happening of an event ("when decision is reached on my appeal"). You must choose and complete one:
Note: This form must be updated every 3 years.

a. ☐ On _______/_______/_______
MM DD YR

b. ☐ Upon the occurrence of the following event: ______________________________________

SIGNATURE AND DATE

____ ____
Signature Date

Personal Representative: If this Authorization is being completed by someone other than the individual to whom the health information relates, this section must be signed.

____ ____
Signature of Personal Representative Date

____ ____
Name of Personal Representative Relationship to Participant or Nature of Authority

_____________________________ _____________________ _______ ________
Mailing Address City State Zip Code

____
Personal Representative's Daytime Phone Number

Submit Form to: Privacy Contact Person
Alaska Electrical Health & Welfare Fund
701 E Tudor, Suite 200
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