

Plan Sponsor: IBEW Local 18

AUTHORIZATION FOR RELEASE OF INFORMATION TO BENEFIT SERVICE CENTER, INC.

I, _____, hereby authorize the use or disclosure of health information about me on the terms and conditions set forth in this authorization.

OR

I, _____, the parent of, _____, authorize the disclosure or use of health information about my minor dependent child, under the terms and conditions set forth in this authorization.

1. The following people or organizations are authorized to provide the information I am releasing (*check all that apply*):

Doctor _____ Medical Group _____ Hospital _____
(Name) (Name) (Name)
 Other _____ Any other Business Associates of
(Name) the Health Plan

2. I authorize Benefit Service Center (BSC) and Other(s): _____, to receive the information.
(Name(s))

3. I understand I am authorizing the use or disclosure of health information pertaining to me or my minor dependent, if applicable, related to the diagnosis, treatment or prognosis with respect to the following physical, accident, illness, medical or mental condition: _____

(ie., back pain, gall bladder removal, orthodontic treatment)

4. If you want any limitations put on the type of medical information to be disclosed, please describe here: _____

(ie., CT Scan only, not doctor's report)

5. You have the option of stating the reason why you have agreed to have personal health information about yourself or your minor dependent disclosed. Or, you may decline to state the reason, and simply check that the information is being "disclosed at the request of the individual [you]".

Resolve outstanding claims issue For Psychotherapy Notes*
 "At the request of the individual" Other: _____

**If this authorization is for psychotherapy notes, it cannot also authorize use or disclosure of any other type of health information. That must be done on a separate authorization form.*

6. I understand that I have the right to revoke this authorization at any time by notifying, in writing, the Privacy Officer, Scott Freeman, of Benefit Service Center, Inc., 9500 Topanga Canyon Blvd., Chatsworth, CA 91311. I also understand the revocation is only effective after it is received and logged by BSC. I understand that any use or disclosure made prior to the revocation will not be affected by the revocation.

7. I understand that after my health information is disclosed pursuant to this authorization, it may be re-disclosed by the recipient to parties not subject to this agreement and the information disclosed may not be protected by federal privacy laws or regulations.

8. I understand that upon written request, I am entitled to receive a copy of this authorization.

9. I understand that my decision to authorize the release of health information is voluntary. My treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I do or do not sign this authorization.

10. This authorization is valid from today's date through:

90 Days the date my insurance coverage ends
 180 Days Other _____

(Insert Date, no longer than 12 months from the date of this authorization)

I initiated this authorization for disclosure of personal health information. I have read and understand this authorization. A copy of this authorization shall be considered as effective and valid as the original.

Print Name

Date

Signature

Health Plan Group I.D. Number (of Covered Participant or dependent)

Home Phone: () - - Work Phone: () - - Email Address: _____

If this authorization is signed by a Personal Representative on behalf of a Covered Participant complete the following:

Print Personal Representative Name

Signature

Date

Relationship to Covered Participant