LINE CONSTRUCTION BENEFIT FUND

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Member Name:_____ **Member Unique ID** _____
(Please Print)

Address: _____

Member Telephone No.:_____

Patient's Name:_____

In the course of providing health plan coverage, the LINE CONSTRUCTION BENEFIT FUND (LINECO) may obtain private health information about you or your dependent child(ren). Except as permitted by law and Federal regulations, LINECO will not disclose that private health information to any person or entity. *LINECO WILL NOT condition payment of a claim, enrollment in a plan or eligibility for benefits on your decision to sign this Authorization Form. You are not required to sign this form.*

This Authorization Form is only effective if it is signed by the person whose medical information is to be disclosed, or by someone authorized to sign for that person. If the person whose medical information is to be disclosed is a child under age 18, a parent living with the child can sign on behalf of the child.

1. **Persons and Organizations Authorized to Receive and Use My Health Information.**

   _____

   I understand that the individual or organization named above are not health care providers or health plans that are subject to Federal privacy standards and that disclosing my health information pursuant to this authorization creates a risk of redisclosure without my authorization.

2. **Persons and Organizations Authorized to Disclose My Health Information.**
   This authorization applies to LINECO and to all of their employees, representatives and agents having access to my health information.

3. **Description of Health Information to Be Used or Disclosed.** In order to enable another person or organization to assist me in obtaining benefits from LINECO, I want this authorization to apply to all information concerning my eligibility and medical treatment. NOTE: This form does not authorize the disclosure, release or use of psychotherapy notes.
   This authorization allows LINECO to disclose and use <u>any</u> health information unless I specify otherwise on the following lines. This authorization DOES NOT apply to:

   _____

   _____

4. **Purpose of the Requested Use and/or Disclosure.** I authorize my health information to be used and/or disclosed for all purposes that the individual or organization named above, in their sole discretion, deem necessary or advisable to assist me in obtaining benefits from LINECO.

5. **Your Rights with Respect to This Authorization.** You have the right to revoke this authorization at any time. Any revocation must be in writing, sent or delivered to 821 Parkview Boulevard, Lombard, Illinois 60148. A revocation will not be effective as to uses and/or disclosures of your health information that have already made in reliance upon this authorization prior to receipt of your written revocation.

6. **Expiration of Authorization.** Unless you do not insert an earlier date or event on the following line this authorization will expire 30 months from the date on which you sign it.

This authorization will expire for the purpose of the use or disclosure on _____**.**

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7. **Authorization.** By signing this Authorization Form, I authorize LINECO and its agents and employees to disclose my health information, subject to the limitations contained in this Authorization Form. I understand that I am under no obligation to sign this form. I have signed this form voluntarily to document my wishes regarding the use and/or disclosure of the health information described on this form. I have had an opportunity to review and I understand the contents of this form.

_____ _____ _____

Patient's Signature ***(age 18 or over)*** **Print Name** **Date**

If Authorization is NOT Signed by Patient

Name of person signing authorization_____

Relationship to Patient or nature of authority (parent, guardian or health care power of attorney)

_____