DC 37 Health and Security Plan
125 Barclay St., New York, NY 10007, 212-815-1234
Authorization To Release Information To Union Officials Assisting With Member Claims

Member last name (print) _____ First name (print) _____ Social Security Number _____

Patient last name (print) _____ First name (print) _____

By signing this form, I authorize the District Council 37 Health and Security Plan to release my health information as set forth in this authorization form.

I authorize personnel within the District Council 37 Health and Security Plan ("The Health and Security Plan") to disclose my health information as follows:

- The following type of health information is permitted to be disclosed with this authorization: Information relating to a specific claim for benefits (insert details describing the claim)

_____

The health information described above will be disclosed by personnel within the Health and Security Plan that otherwise have access to such information as part of their job function.

The health information described above will be used by and/or disclosed to District Council 37 representatives who assist with member advocacy issues in the normal course of their job.

The health information described above will be used and/or disclosed for the following purpose. To allow District Council 37 representatives (i.e. Local Presidents, shop stewards, etc) to assist me with a claim for benefits under the Health and Security Plan.

I understand that I have the right, at any time, to revoke this authorization by submitting a written notice stating I wish to revoke this authorization to (the Department Manager of the relevant claim area)

However, I understand that I may not revoke this authorization to the extent that the Health and Security Plan has already taken action based on it.

I also understand that to the extent my revocation is effective, it will take effect as of the date it is received and processed by the person or department identified above. I understand my revocation will not affect the use or disclosure of my health information, as permitted by this authorization, before the effective date of the revocation.

I understand that any health information disclosed under this authorization may be subject to re-disclosure and no longer protected by the privacy provisions of the Health Insurance Portability and Accountability Act ("HIPAA").

I understand that I am entitled to a signed copy of this authorization. (An additional form is attached for your records.)

I understand that this authorization will expire at the time the claim issue identified in this authorization is resolved.

_____ _____

Signature of Patient **Date**

(Provide the following information if this form is not signed by the individual whose health information is described in this form.)

I am a personal representative of _____ by the authority granted to me by _____ (attach appropriate documentation).

_____ _____ _____

Personal representative name (print) **Personal representative signature** **Date**