HAWAII LABORERS TRUST FUNDS

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ANNUITY - HEALTH & WELFARE - LECET - PENSION - TRAINING - VACATION

Effective as of __________

Authorization for the Use and Disclosure of Individually Identifiable Health Information

Please fill out the authorization form completely as Hawaii Laborers' Health and Welfare Trust Fund Office cannot respond to your request without this information. This authorization form is required for Hawaii Laborer's Health and Welfare Trust Fund Office to release information to someone other than yourself for purposes outside the Hawaii Laborers Health and Welfare Trust Fund Office's normal operations (treatment, payment of claims, or healthcare operations).

Patient's Name:______________________________ Date of Birth:_____________

Member's Name:_____________________________ Date of Birth:_____________

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that the information I authorize a person or entity to receive may be re-disclosed and no longer protected by federal privacy regulations.

1. Specific description of information that may be disclosed:
   ____
   ____
   ____

2. The information will be disclosed for the following purpose(s): (If you do not wish to state a purpose, please state, "At the request of the individual".)
   ____
   ____
   ____

3. The organization authorized to disclose the information
   <u>Hawaii Laborers' Health and Welfare Trust Fund Office</u>

4. Persons/organizations authorized to receive the information:
   ____
   ____
   ____

5. I understand that this authorization is voluntary and that I may refuse to sign thus authorization. My refusal to sign will not affect my eligibility for benefits or enrollment, payment for or coverage of services, or ability to obtain treatment, except as provided under numbers 6 and 7 on this form.

6. If the purpose of this authorization is for Hawaii Laborers' Health and Welfare Trust Fund Office to determine eligibility before enrollment, the requested use or disclosure is not for psychotherapy notes, and I refuse to sign this authorization, Hawaii Laborers' Health and Welfare Trust Fund Office reserves the right to deny enrollment and eligibility for benefits.

7. If the purpose of this authorization is to disclose health information to another party based on health care that is provided solely to obtain such information, and I refuse to sign this authorization, Hawaii Laborers' Health and Welfare Trust Fund Office reserves the right to deny that health care.

8. I understand that I may inspect or copy the information used or disclosed.

9. I understand that I may revoke this authorization at any time by notifying Hawaii Laborers' Health and Welfare Trust Fund Office in writing, except to the extent that:
   a) action has been taken in reliance on this authorization; or
   b) if this authorization is obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right tot contest a claim under the policy or the policy itself.

10. I understand that I have a right to request and receive a Notice of Privacy Practices from Hawaii Laborer's Health and Welfare Trust Fund Office.

11. This authorization expires on ___________________.

Signature of patient or patient's representative	Date
Printed name of patient or patient's representative	Relationship to patient, or representative's authority to act for the patient, if applicable