NORTH CENTRAL ILLINOIS LABORERS' HEALTH & WELFARE FUND

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION TO A UNION OR EMPLOYER

Federal law prohibits insurers from sharing your health information without permission except in certain situations. This form authorizes the North Central Illinois Laborers' Health & Welfare Fund ("Fund") to share protected health information with the person(s) designated below.

Section 1: Recipient of Information and Description of Information to be Released

I, _____, give permission for the **Fund** to share my protected health information as designated below:

Share with representatives of _____, the following information:

LOCAL UNION OR EMPLOYER TO RECEIVE INFORMATION

(EXAMPLE – Laborers' Local #32, 165, 362, 393, 538, 727, 751, or 996 or ABC CONSTRUCTION)

(Check Appropriate Box – More than One Box may be selected)

☐ All **My Eligibility Information** (including, but not limited to, information regarding hours worked, dates of eligibility, COBRA eligibility and self-payments).

☐ All **My Medical Claim Information** that is received or maintained by the Fund which will include (i) information regarding all my health/medical conditions (including, but not limited to, chronic diseases, behavioral health conditions, substance abuse conditions, communicable diseases (including HIV/AIDS), and genetic information, but excluding psychotherapy notes), and (ii) information regarding the payment of claims, medical diagnosis, dates of service, case management, appeals and any other claims information or records related to my health/medical conditions received by the Fund.

☐ **Other (Please Specify)_____**

_____

Section 2: Purpose for Disclosure

Check one: ☐ At my request. ☐ Other_____

Section 3: Expiration/Revocation

This authorization will expire (check one box only):

☐ **The later of when I revoke this authorization or when I lose eligibility with the Fund.*****

OR

☐ **Upon the following date:_____/_____/_____**

For the authorization to be effective, one of the above boxes must be checked/completed.

***If you check this box, you agree that this authorization will remain in effect until termination of your enrollment/eligibility with the Fund or you revoke your authorization in writing. Additionally, unless you revoke this authorization in writing, you further agree that this authorization will remain in effect during all periods of your eligibility (including periods of eligibility between periods of ineligibility). Your request to revoke this authorization will be effective the day it is received by the Fund Office. Note, any use or disclosure made prior to the revocation of this authorization will not be affected by the revocation.

Section 4: Approval and Signature

I understand that this authorization to release protected health information is voluntary and is not a condition of enrollment in the Fund, eligibility for benefits, or payment of claims. I also understand that if the person(s) or organization(s) I authorize to receive the information described above is not subject to federal health information privacy laws, they may further release the protected health information, and it may no longer be protected by federal privacy laws.

By signing below, I authorize the release of my protected health information as described above.

Signature	
Print Name	Date

If signed by a person other than the individual identified on this form, complete the following:

1) Individual is: ☐ a minor ☐ legally incompetent or incapacitated ☐ deceased
2) Legal Authority: ☐ parent * ☐ legal guardian* ☐ Power of Attorney* ☐ executor of deceased*

*By signing the above, I agree to produce any documents required to confirm my legal authority as noted above before this authorization can be effective.

Return the Completed Form to:

North Central Illinois Laborers' Health and Welfare Fund
4208 W. Partridge Way Unit 3
Peoria, IL 61615
Facsimile: 309.692-0862
email: ncil@ncil.us

INSTRUCTIONS FOR COMPLETING THE AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

FOLLOW THESE STEPS TO COMPLETE THE FORM CORRECTLY. FOR THE AUTHORIZATION TO BE VALID, YOU MUST COMPLETE THE ENTIRE FORM.

SECTION 1: WHO CAN RECEIVE YOUR INFORMATION & WHAT WILL BE SHARED

1. Enter Your Full Name in the space provided.
2. Enter the Name of the Union or Employer (e.g., "Laborers' Local #165" or "ABC Construction").
3. Choose What to Share – Check one or more boxes:

☐ Eligibility Information – Includes hours worked, dates of eligibility, COBRA eligibility, and self-payments.
☐ Medical Claims Information – Includes diagnoses, treatment dates, payment details, and medical conditions (including substance abuse, communicable diseases, etc.). Psychotherapy notes are excluded.
☐ Other – Write in any specific information you wish to share.

SECTION 2: REASON FOR SHARING

Check one:

☐ "At my request" – Use this if no specific reason is needed.
☐ "Other" – Write in your specific reason (e.g., union assistance, employment verification, etc.).

SECTION 3: WHEN THIS AUTHORIZATION EXPIRES

Check only one box:

☐ "The later of when I revoke this authorization or when I lose eligibility with the Fund." → This keeps the authorization in effect until you cancel it or your coverage ends.
☐ "Upon the following date:" → Write a specific expiration date if you want to set one.

To revoke this authorization later, you must REVOKE this authorization in writing and provide it to the Fund Office.

SECTION 4: SIGN AND DATE

1. Sign your name to approve the release.
2. Print your name clearly.
3. Write the date you sign.

IF SOMEONE ELSE IS SIGNING ON YOUR BEHALF

If you're not signing for yourself, the signer must:

1. Check the correct status of the individual: ☐ Minor ☐ Legally Incompetent ☐ Deceased
2. Check the legal authority: ☐ Parent ☐ Legal Guardian ☐ Power of Attorney ☐ Executor
3. Be prepared to provide proof of their legal authority (e.g., court order, power of attorney document).

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