P.O. Box 4100 · Concord, CA 94524-4100
Telephone: (800) 552-2400 · Facsimile: (925) 746-7549
www.ufcwtrust.com

UFCW & Employers Trust Authorization Form

If you want the UFCW & Employers Trust (the "Plan") to use and disclose your Protected Health Information (PHI) (or the PHI of a Participant you represent) in a way that requires your (or his or her) authorization, please complete this Authorization and submit it as instructed below. Refer to the Plan's Notice of Privacy Practice for a description of PHI, and uses and disclosures of the PHI of Participants that require the authorization of such Participants. For purposes of this form, "Participant" means a primary Plan participant or the covered spouse or dependent of such participant (as applicable).

1. Participant's name:_____

2. Participant's Fund ID#:_____

3. Participant's birthdate: _____

4. (a) Requestor's name:_____
(if form is completed by someone other than the Participant, e.g., a Personal Representative such as a parent or other legal guardian or person with power of attorney*)

(b) Requestor's Relationship to Participant:_____

(c) Requestor's birthdate:_____

(d) Requestor's Plan ID# (if applicable):_____

5. Describe the specific PHI that you authorize the Plan to use or disclose. For example, describe the (i) health records you authorize the Plan to disclose by date(s) of service, treatment, and/or name of doctor(s) or other health care provider(s); (ii) your eligibility information; and/or (iii) information related to your appeal from a claim denial: _____

6. (a) If this authorization is at your request, you may initial here _____ to state that the purpose is "At the request of the individual." Otherwise, describe the specific purpose of the disclosure:_____

(b) Provide the name and contact information for each person or entity to whom the above described PHI may be disclosed. Attach additional sheets, if necessary.

Name of Person/Entity	Telephone Number	Name of Person/Entity	Telephone Number
Street		Street	
City	State / Zip Code	City	State / Zip Code

7. This Authorization will expire _____ [insert expiration date or event relating to you personally]; otherwise, this Authorization will remain in effect for one year or until revoked by you in writing, whichever is earlier.

Read and sign the following statement:

I authorize the Plan to use and disclose my PHI as described above. I understand that: 1) PHI disclosed in accordance with this Authorization may be re-disclosed by the recipients listed in this Authorization and, as a result, may no longer be protected under applicable health privacy laws or under the Plan's privacy practices. 2) Payment of my Plan claims and eligibility for my Plan benefits are not affected by my decision to complete this Authorization. 3) This Authorization is valid until the revocation date indicated above, or until I revoke it in writing. I understand that I have the right to revoke this Authorization at any time by writing to the Plan at the address below, except to the extent that the Plan has already used or disclosed my PHI in reliance on this Authorization.

Signature:*_____ Date:_____

**If you are making this request on behalf of another individual, a completed Personal Representative form must be on file with the Plan unless the individual is your minor dependent child or ward and you also participate in the Plan.*

This completed Authorization must be received by the Plan at: Health & Welfare Services - HIPAA, UFCW & Employers Trust LLC, 1000 Burnett Ave., Suite 110, Concord, CA 94520-2000**.** Fax: [(925) 746-7549]. *If you have questions about this Authorization form, contact Health & Welfare Services at* [(800) 552-2400].

For internal Plan use only. Date received:_____ Date Revoked:_____