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

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Please check the appropriate Fund(s):

☐ **UFCW & Employers Benefit Trust (UEBT)**

☐ **UFCW Comprehensive Benefits Trust (UCBT)**

☐ **UFCW Northern California& Drug Employers Health & Welfare Trust Fund**

PLEASE PRINT

By signing below, I authorize the UFCW-Employers Benefit Plans of Northern California Group Administration LLC (the "LLC") and/or the Fund(s) checked above to disclose the personal health information of the person named below, to the staff of UFCW Local _____, as follows:

(Check one)

☐ I authorize release of the medical information to any staff member of UFCW Local _____.

OR

☐ I authorize release of the medical information only to those UFCW Local _____ staff members named here:_____

_____

Name and Social Security Number of person whose health information may be disclosed:

Name: _____

Social Security #:_____ or Member ID #: _____

I authorize the LLC and/or the Fund to release information related to the person named above and his or her: (1) claim(s) for benefits; (2) eligibility for benefits; (3) payments made to providers on his or her behalf; and/or (4) appeal(s) of the denial of benefits, related to the following:

(describe the injury or illness to which the claims or appeals relate, including dates, or give dates of eligibility in question, or attach copies of claims, bills, or correspondence containing this information):_____

_____

OVER

☐ Check here if you have attached claim forms, bills, trust fund correspondence or other documents containing details of the claims or appeals related to this Authorization.

This Authorization is made at my request to allow the LLC staff and/or the Fund staff to discuss the claims and/or eligibility for benefits of the person named above with the Union staff. I understand that after the Union staff receives and uses the health information, federal law might not protect the information, and the Union staff that received and used the health information might disclose it again. However, I have the right to seek assurances from the Union staff identified above that they will not re-disclose the health information to any other party without my express, additional authorization to do so.

I understand that neither the LLC nor the Fund will condition treatment, payment, enrollment or eligibility for health plan benefits on whether or not I sign this Authorization.

I understand that I am entitled to receive a copy of this Authorization.

I understand that this Authorization is voluntary, and that I may revoke it at any time by sending a written request to revoke to the LLC or the Fund at the address above. I understand that the revocation will only be effective after the LLC or the Fund receives and logs my revocation, and any use or disclosure made under this Authorization before the revocation is logged will not be affected by the revocation.

This authorization will expire on _____, or one year from the date of my signature below, whichever is earlier.

Signature of Person or Personal Representative

_____ _____
Signature of Person Date Signed

OR

_____ _____
Signature of Person's Personal Representative Date Signed

The personal representative signing this Authorization warrants that he or she has the authority to do so on the following basis:

☐ Appointment of Personal Representative form filed with the Trust Fund Office

☐ Parent of Person about whom health information will be disclosed

☐ Power of Attorney for Health Care (attach document)

☐ Other (describe and attach documents):_____
_____
(e.g., Appointment of Conservator or Guardian)