



Carpenters Southwest Administrative Corporation

ADMINISTRATIVE OFFICE: 533 S Fremont Ave. • Los Angeles, CA 90071-1706 • Tel: (213) 386-8590 • Toll Free (800) 293-1370

www.carpenterssw.org

SUBJECT: HIPAA AUTHORIZATION FORM

To provide you with the benefits to which you are entitled, the Southwest Carpenters Health & Welfare Trust (the “Trust”) must collect, create and maintain information about you. We at the Trust are concerned about the privacy of this information which is referred to as “**Protected Health Information**” or “**PHI**” under the Health Insurance Portability and Accountability Act of 1996 (“**HIPAA**”). To protect PHI, HIPAA requires health plans such as the Trust to set up new policies and procedures regarding how they use and disclose information about participants such as you.

The Notice of Privacy Practices that has been mailed to all members of the Trust’s health plans describes how the Trust may use and disclose Protected Health Information about you, as well as, the Trust’s obligations and your rights with respect to that information. If you would like another copy of the Notice of Privacy Practices, you may request one by calling the Trust Office at (213) 385-0551.

HIPAA establishes limits on those with whom the Trust can discuss your Protected Health Information when you are not present for the conversation. These limits include information regarding your eligibility and the eligibility of your covered dependents, treatment dates and the reasons for any denial of benefits. If you want to authorize the Trust Office to discuss this type of Protected Health Information with another person, including your spouse or a business agent or other staff member of a Union Local or Regional Council, you must complete the Trust’s standard Authorization Form. Generally, you will not need an authorization to obtain Protected Health Information about your minor children. However, you will need an authorization to obtain Protected Health Information about covered dependents that are adults.

You may obtain additional information regarding authorizations by writing to Brooke Reid, Privacy Officer, CSAC, 533 S. Fremont Avenue, Los Angeles, CA 90071.

Arizona

Satellite Office
4547 W. McDowell Rd. Ste. 6
Phoenix, AZ 85035-4124
(602) 352-6805

Nevada

Satellite Office
980 Kelly Johnson Dr., Ste. 180
Las Vegas, NV 89119-3722
(702) 851-4510 • (800) 501-0210

New Mexico

Satellite Office
3900 A Pan American Freeway, NE Ste. 120
Albuquerque, NM 87107-4747
(505) 266-8869

Southwest Carpenters Health & Welfare Trust
Authorization Form

Your Name: _____
Please Print (Your Signature will be Required Below)

Birth Date: ____/____/____
MM / DD / YY

Your relationship with Member: Self Spouse Dependent Child

Member's Name: _____

Member's Social Security Number or Member Number: _____

Address: _____

Home Telephone Number: _____ Work Telephone Number: _____

I hereby authorize the Southwest Carpenters Health & Welfare Trust (the "Trust") to use and/or disclose my Protected Health Information as follows:

1. **Information to be Used or Disclosed.** The following Protected Health Information (PHI) may be used and/or disclosed as described below (Check those that apply):

- Any health care information that you have about me.
- Any information that relates to my eligibility for benefits provided by the Trust.
- The dates of treatment that I received.
- The reason(s) that I was denied benefits.
- Other _____

[Please describe the information in specific and meaningful fashion]

2. **Persons to Whom the Use or Disclosure May be Made.** The following person(s) or class of persons may receive the Protected Health Information described in Section 1 of this Authorization from the Trust and/or CSAC for the purposes described in Section 4 of this Authorization.

- Spouse's Name: _____
- Child(ren)'s Name(s): _____
- Parent(s)' Name(s): _____
- Business agent or other staff member of Union Local or Regional Council
- Other Name: _____

[List the name or specific identification of the person or classes of persons]

If you only want your PHI released to someone who knows a password, write your password here:

3. **Expiration Date or Event.** This authorization will expire (choose and complete one):

Ten years from the date this authorization is signed

On ____ / ____ / ____ (Less than 10 years from the date authorization is signed)
MM / DD / YY

Upon the occurrence of the following event(s) related to my health care or to the purpose(s) for which I have authorized the use and/or disclosure of my Protected Health Information:

I understand that:

- (1) I may revoke this Authorization in writing at any time except to the extent that the Trust has taken action in reliance on this Authorization;
- (2) The Trust may not condition treatment, payment, enrollment or eligibility for benefits on my willingness to sign this Authorization; and
- (3) Any information disclosed under this Authorization may be subject to redisclosure by the recipient and may no longer be protected by law.

By: _____ Date: _____
[Your Signature]

Please mail to CSAC, 533 S. Fremont Avenue, Los Angeles, CA 90071 or fax to 213.739.9318