NORTHERN CALIFORNIA PIPE TRADES TRUST FUNDS FOR UA LOCAL 342

AUTHORIZATION FOR RELEASE OF BENEFIT INFORMATION

I. Information about the use or disclosure of Protected Health and Benefit Information (PHI)

Participant, Retiree,
or Surviving Spouse: _____ Social Security No. xxx-xx-_____

I, (patient's name) _____, hereby authorize the use or disclosure of my written, electronic and oral protected health information (PHI), as described in this authorization.

1. Specify the individual/organization authorized to receive your health information (i.e. spouse, child, parent etc.):
   Name: _____ Phone Number: (___)_____ Relationship: *_____
   Name: _____ Phone Number: (___)_____ Relationship: *_____
   Name: _____ Phone Number: (___)_____ Relationship: *_____
   **** Any change in life circumstances that alters the relationship you have listed may invalidate this authorization*.**

2. Check the applicable box below to specify the individual/organization authorized to provide your health information:
   - ❑ Northern California Pipe Trades Trust Funds (*This applies without restriction, only to benefits administered at the Trust Fund Office*)
   - ❑ Specify below if limiting authority

   _____

3. Check the applicable box below to describe the information you wish the Trust Fund Office Staff to disclose, as appropriate within the Office:
   - ❑ All benefit issues; **or**
   - ❑ Other, please indicate specific circumstance: _____

4. Check the applicable box below for the purpose of this request:
   - ❑ To discuss benefits with the Trust Fund Office so I can better understand my benefits; **or**
   - ❑ At the request of the individual / organization listed in item 1 above.

5. This authorization will expire on:
   - ❑ Indefinitely: **or**
   - ❑ Specified Date: _____

II. Important information about your rights - I have read and understand the following statements about my rights:

- I understand that I have the right to revoke this authorization at any time by notifying the Privacy Officer in writing at 1855 Gateway Blvd., Suite 350, Concord, CA 94520-8445. I understand that the revocation is only effective after it is received and processed by the Plan. I understand that any use or disclosure made prior to the revocation under this authorization will not be affected by a revocation.
- I understand that after this information is disclosed, federal law might not protect it and the recipient might disclose it again.
- I understand that I am entitled to receive a copy of this authorization.
- I understand the Plan will not condition treatment, payment, enrollment, or eligibility for benefits on receipt of an authorization.
- I understand that if I have authorized my spouse to receive information, this PHI access designation would be invalidated upon notification to the Trust Fund Office of a separation in any form or divorce.

You may refuse to sign this authorization. The refusal will not affect your ability, according to the Plan's provisions, to obtain treatment, receive payment of benefits or eligibility for benefits unless authorized by law.

III. Signature of Patient: _____ Date: _____

Please return this form to: Kim Biagi
NCPTTF Privacy Officer
1855 Gateway Blvd., Suite 350
Concord, CA 94520-8445

Phone: 925/356-8921 800/780-8984
Fax: 925/356-8938
Email: tfo@ncpttf.com