United Food and Commercial Workers Unions and Employers Midwest Health Benefits Fund
9801 West Higgins Road, Suite 500 ♦ Rosemont, IL 60018-4740 ♦ 847-384-7000 ♦ 800-621-5133
Customer Service FAX 847-384-0196 ♦ ufcwmidwest.org

Plan B5 or Plan 7: Authorization for Release of Personal Health Information

Federal law requires that every adult covered person must give a written authorization before we may disclose personal health information to another person, such as a spouse, about the individual's treatment or coverage. If an authorization is not on file, we can disclose information **only** to the covered person.

Please complete and return this form to us so that we know to whom we are authorized to disclose information regarding your health benefits coverage and medical treatment. You may name your spouse and/or anyone else, such as a friend. To add more than one additional person, please list their name and relationship and your signature and date on the back of the form. Health care providers (doctor, hospital, etc.) do **not** need to be listed on this form.

Employee-Member Information

FULL NAME (EMPLOYEE-MEMBER)	UFCW ID# OR SOCIAL SECURITY NUMBER	DAYTIME AREA CODE/PHONE NUMBER

STREET ADDRESS	CITY	STATE	ZIP

By signing below, I have authorized the United Food and Commercial Workers Unions and Employers Midwest Health Benefits Plan to disclose my health information as described in this Authorization. I have had an opportunity to review and understand the contents of this entire form and I am confirming that it accurately reflects my wishes:

☐ I am the Employee-Member and I authorize you to disclose information to my spouse,

_____
spouse name

Signature _____ Date Signed _____

☐ Additional Authorization. I am the Employee-Member and I authorize you to disclose information to:

_____
name and relationship

Signature _____ Date Signed _____

Description of Information to be Disclosed by the Plan. I understand that the information that may be disclosed by the Plan will include all information created by or received by the Plan related to my medical treatment, health conditions, eligibility for health benefits and/or payment of health benefits by the Plan.

Expiration of Authorization. This authorization will expire (1) upon the termination of my coverage under the Plan, (2) as to a person who has authorized disclosure to his/her spouse, upon the dissolution of marriage, or (3) when I revoke the authorization in writing.

Right to Revoke. I understand that I have the right to revoke this authorization at any time by notifying the Benefits Fund Office in writing. I further understand that the revocation is effective only after it is received at the Benefits Fund Office and that any use or disclosure made prior to the revocation will not be affected by the revocation.

Voluntary. I understand that I am under no obligation to sign this authorization form. I acknowledge I am voluntarily signing this form to release my health information to the party I have designated.

Benefits Not Conditioned on Authorization Form. I understand that eligibility for benefits is not conditioned on this authorization form.

Potential for Redisclosure. I understand that after my health information is disclosed, federal law might not protect it, and the recipient might redisclose it.

Right to Copy. I understand that I am entitled to receive a copy of this authorization.

Photocopy and Facsimile. A photocopy or facsimile of this signed authorization form shall be considered as valid as an original signed copy.

Purpose of Disclosure: This form authorizes the Plan to disclose my personal health information to the person(s) designated pursuant to my individual request.