United Food and Commercial Workers Union and Employers Calumet Region Insurance Fund
Authorization for Release of Protected Health Information (PHI)

I. Information About the Use or Disclosure PHI

Participant name: ________________________ SSN(last 4)/ID:________________

I, ______________________hereby authorize the use and disclosure of PHI for (*insert name of individual whose information is to be released*) ________________________as described below:

1. Organization authorized to release and/or disclose PHI:
   ☒ Zenith American Solutions (third party administrator for the Trust Fund)
   ☐ Other, please specify: ______________________________

2. Person or organization (or class of persons/organizations) authorized to receive the information:
   Name: ______________________________ Daytime Telephone: (   ) -
   Address: ______________________________

3. Check the boxes to describe the specific description of information to be used or disclosed:
   ☐ Related to eligibility for benefits for the period of ____________through ______________
   ☐ Related to claims, reports and other documents for benefits for an injury or illness
   ☐ Related to payment or lack of payment of benefits for all health care providers
   ☐ Related to an appeal for benefits that has been denied
   ☐ Other:______________________________

4. Specific purpose of the disclosure, for example "To discuss benefits with the Trust Fund so I can better understand my benefits." If you do not wish to state a specific purpose, state "At the request of the individual": ____________
   ____

5. This authorization will expire on (give a date or occurrence – for example, "Upon termination of enrollment in the health plan."): ______________________________
   ____

II. Important Information About Your Rights

I have read and understand the following statements about my rights:

- This authorization is voluntary and I may refuse to sign it.
- I may revoke this authorization at any time prior to its expiration date by sending a written revocation notice to the Privacy Officer at 18861 90th Ave, Suite A, Mokena, IL 60448 or Privacy Fax: 702-216-0885. The revocation will not have any effect on any actions that the entity took before it received the revocation notice.
- I am not required to sign this authorization as a condition to receiving treatment or payment for health care; enrolling in a health plan; or establishing eligibility for benefits.
- The information that is used or disclosed pursuant to this authorization may be redisclosed by the receiving person or organization and, upon redisclosure, no longer be protected by federal privacy laws.

III. Signature of Individual or Personal Representative* making the request

______________________________ ____________________
Signature Date

Address: ______________________________ Daytime Telephone: (   ) -

IV. *If the form is signed by a Personal Representative, complete the following information (a *personal representative is someone who has authority under applicable law to act on someone's behalf, such as a parent, guardian or durable power of attorney. Please submit a copy of such legal document, if applicable):*

Printed name of the participant's Personal Representative: ______________________________

Relationship to the participant, including authority to act as Personal Representative: ____________________

Please return this form to: Privacy Officer, 18861 90th Ave, Suite A, Mokena, IL 60448 or Privacy Fax: 702-216-0885