How to Fill out a HIPAA Authorization Form

To begin, it is important to know what HIPAA says about release of personal health information. In general, only you may have unlimited access to your records. Doctors and health plans may discuss your information as necessary to do their jobs, but may not disclose your information to other people outside of the bounds of treatment, payment, or healthcare operations without your express authorization to do so. As a result, friends, family, Union Trustees, etc. that may have previously discussed your protected health information (PHI) with the Fund will no longer be permitted to do so after April 14, 2003 without an Authorization to Disclose PHI Form on file for them.

Furthermore, any dependents that you provide benefit coverage for may also have similar restrictions on their PHI. In the past, a husband could obtain information about his dependant spouse from the Fund Office. Under the new world of HIPAA, the dependant spouse would need to authorize her husband as an appropriate recipient of her PHI, and vice versa. Children above the age of 18 will also need to sign authorizations allowing their parents to access PHI.

To most effectively keep your PHI flowing to those individuals to whom you wish to provide access, please follow these instructions in filling out the Authorization for Disclosure of PHI form:

1. Fill in your name in the line titled "Individual's Name" and your Social Security Number in the "SSN" space.
2. Choose the scope of the PHI for which you wish to authorize disclosure. If you want a spouse to discuss any topic related to your PHI with the Fund Office, then choose the "All claim(s) and other information related to my healthcare." If you only wish to offer the recipient access to a portion of your PHI, please choose one of the other selections. An example of this would be if you care to designate a Union Trustee as an authorized recipient of PHI related to only one round of medical treatments and the claims associated with that period of treatment.
3. Provide contact information on the person you are authorizing to obtain PHI. This information is required since HIPAA requires the Fund to gather enough information to verify the identity of the person on the phone requesting PHI. So if your spouse calls with questions about you, and they have a valid authorization on file, the Fund will still be unable to verify information about you and them. In most cases, the Fund will require that they be able to provide the contact information about them that was provided on the Authorization.
4. Choose the duration of the authorization. Most people will choose "the duration of the individual's eligibility with the Fund" since it is the most broad timeframe and decreases the need for additional authorizations. However, if you only wish to have this person access PHI for a specific period of time, you may choose another time period accordingly.
5. Review the numbered statements and sign your initials in the space provided.
6. Review the waiver statement and sign and date the authorization.
7. If you are have legal rights as a personal representative for a participant and are filling out this form on their behalf, please attach a copy of your proof of representation (Durable Power of Attorney documents, etc.).
8. Mail the form to:

   St. Louis Graphic Arts Joint Health and Welfare Fund
   14323 S. Outer Forty Road
   Suite N204
   Chesterfield, Missouri 63017
9. You may also expedite the process and fax this form to the Fund Office at (314) 275-2640.

Authorization for Disclosure of PHI Form

(Please provide a response to each bold field and return this form to the address or fax number listed)

Individual's Name: _____ **SSN:** _____

I authorize the disclosure of PHI related to (choose one):

□ All claims and other documents related to my healthcare	□ Other: _____ _____
□ Specific claim(s) data– Please provide Date of Service and Provider Name or other information specifically identifying the claim(s) _____	

Entity authorized to disclose PHI:	**Person(s) authorized to receive PHI:**
St. Louis Graphic Arts Joint Health & Welfare Fund (the Fund)	**Name:**
14323 S. Outer Forty Road, Suite ~~N204~~ S106	**Address:**
Chesterfield, Missouri 63017	
Administration -(314) 878-1579 Claims – (314) 275-8080 Fax – (314) 275-2640	**Phone #:**

This disclosure of PHI is made at the request of the individual unless otherwise noted here:

_____

Expiration Details (choose one):

□ This authorization is valid for the duration of the individual's eligibility with the Fund

□ This authorization expires on _____/_____/_____ (DD/MM/YR)

□ This authorization expires in the event of (please describe an applicable expiration event):

_____

1. I understand that I may revoke this authorization at any time by notifying the Fund in writing. Details on the conditions of revocation may be found in the Fund's Notice of Privacy Practices, which is available upon request. In the case of revocation, I understand that changes will not be considered applicable to any actions taken before receipt of the revocation.
2. I understand that the payment for my healthcare benefits will not be affected if I do not sign this form unless the Fund specifically requires this authorization to determine eligibility or enrollment information, or requires this document for use in underwriting or risk determination.
3. I understand that I may request to review the information described on this form, and that I may request a copy of this form after I sign it.

Initials:_____

I, the undersigned, have read the above information and hereby authorize the use or disclosure of my individually identifiable health information for the purpose described above. I understand this authorization is voluntary. I understand if the person/entity authorized to receive the information is not bound by HIPAA, the released information may no longer be protected by federal privacy regulations. Furthermore, I release St. Louis Graphic Arts Joint Health and Welfare Fund from any liability for any release made as a result of this authorization.

(Form must be fully completed before signing)

_____

Signature of individual or representative **Date**

For personal representatives, please attach a copy of documentation detailing legal responsibility.