Operating Engineers Local 825 Fund Service Facilities

65 Springfield Avenue, Second Floor
Springfield, New Jersey 07081
(973) 671-6800

Pre-Cert and PPO
(800) 677-3237

Date:_____

Member:_____

Dependent:_____

From:_____
(Claims Dept.)

To Whom It May Concern:

The enclosed form is for you or your personal representative to authorize the Welfare Fund to release your protected health information to another person or organization at your request.

This form must be completed in its entirety before signing and returning to the Funds Office. If you have any questions, please call the Funds Office at 973-671-6800.

Enclosure

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

This authorization allows Operating Engineers Local 825 Welfare Fund to release your protected health information to a person or organization you choose. You can revoke this authorization at any time by submitting a written request to Operating Engineers Local 825 Welfare Fund, 65 Springfield Avenue, Second Floor, Springfield, NJ 07081. Revoking this authorization will not affect any action taken prior to receipt of your written request.

I hereby authorize Operating Engineers Local 825 Welfare Fund to release my protected health information as described below.

Name of Individual Whose Information Will be Released _____
(please print)

Member's Social Security No. _____

Name of person or organization that will receive your information:

_____
Person's Name or Organization

_____
Address (including zip code) Telephone No.

Specific Description of Information to be Released (for example, claim related to service on (date); appeal information related to my claim on (date):

_____

_____

_____

Purpose of Release (If you do not wish to state a purpose, state "At my request"):

_____

Expiration (when this authorization will end):

This authorization will expire on _____/_____/_____/ (mm/dd/yyyy) OR on the occurrence of the following event:

_____
(Examples: Until I revoke authorization; Resolution of specific issue)

I understand that this authorization is voluntary and is not a condition of enrollment, eligibility, treatment or payment of benefits. I also understand that after this information is released, federal law might not protect it and the recipient might redisclose it.

Signature of Individual Whose Information Will Be Released or Individual's Personal Representative

Date

Printed Name of Personal Representative (if applicable)

Telephone No.

(Description of Personal Representative's Authority)