Connecticut Laborers' Health Fund

Disability Income Benefits

Authorization for Release of Protected Health Information

I, _____ hereby authorize the use and disclosure of my protected health information as described in this authorization to process my claim for Disability Income Benefits in connection with the disability which began on or about _____(date).

1. **SPECIFIC PERSON/ORGANIZATION (*OR CLASS OF PERSONS*) AUTHORIZED TO PROVIDE THE INFORMATION:**

   The Connecticut Laborers' Health Fund; and

   The following named physician and/or medical group or any subsequent physician or medical group who may provide medical treatment and/or information with respect to my disability which began on the date previously referenced:

   NAME: _____

   ADDRESS: _____

   _____

   PHONE: _____

2. **SPECIFIC PERSON/ORGANIZATION (*OR CLASS OF PERSONS*) AUTHORIZED TO RECEIVE AND USE THE INFORMATION:**

   Disability Income Benefits Department at the Connecticut Laborers' Health Fund.

3. **DESCRIPTION OF THE INFORMATION TO BE DISCLOSED:**

   From Connecticut Laborers' Health Fund: Eligibility information including name, address, date of birth, social security number, hours worked and eligibility for health benefits and any claims information and documentation to substantiate claim for disability that began on the date previously referenced.

   From Physician described in 1. above: Medical records and/or summary including oral information regarding disability that began on the date previously referenced.

3. **PURPOSE OF REQUEST.** The purpose of this request is to determine initial and continued eligibility for a claim for Disability Income Benefits from the Connecticut Laborers' Health Fund.

4. **RIGHT TO REVOKE**: I understand that I have the right to revoke this authorization at any time by submitting a cancellation in writing to the Connecticut Laborers' Health Fund. I understand that

the revocation takes effect as of the cancellation date or event, or once the Connecticut Laborers' Health Fund receives the written cancellation. I also understand that cancellation of this authorization may result in a determination of ineligibility or discontinuation of Disability Income Benefits due to the Connecticut Laborers' Health Fund's inability to receive necessary information to make such a determination. I understand that any use or disclosure made prior to the revocation under this authorization will not be affected by a revocation.

5. I understand that after this information is disclosed, federal law might not protect it and the recipient might disclose it again.

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

7. I understand that this authorization will expire on the date that my receipt of Disability Income Benefits ends.

8. I understand that this authorization applies only to Disability Income Benefits from the Connecticut Laborers' Health Fund and that the Plan will not condition treatment, payment, enrollment or eligibility for medical benefits on receipt of an authorization.

_____ _____

SIGNATURE OF INDIVIDUAL **DATE**

_____

SOCIAL SECURITY NUMBER

If a Personal Representative executes this form, that Representative warrants that he or she has authority to sign the form on the basis of:

_____