North Atlantic States Carpenters
Health Benefits Fund

Massachusetts Office
350 Fordham Road
Wilmington, MA 01887
www.carpentersfund.org
Phone: 800-344-1515
Fax: 978-752-1148

Connecticut Office
10 Broadway
Hamden, CT 06518
www.ctcarpentersfunds.org
Phone: 800-922-6026
Fax: 203-288-3235

Authorization for Release of Protected Health Information

I _____(Please Print Name) hereby authorize the use or disclosure of my health information as described in this authorization.

My date of birth: _____

My Social Security Number: _____

My Home Address: _____

By signing this authorization form, I authorize the North Atlantic States Carpenters Health Benefits Fund to use and/or disclose my health information (information that constitutes protected health information as defined in the Privacy Rule of the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996) in the manner described below. I understand that I am under no obligation to sign this form. I have signed this form voluntarily to document my wishes regarding the use and/or disclosure of the health information described below in Section 3 of this form.

1. Specific organization authorized to provide the information:
   North Atlantic States Carpenters Health Fund

2. Specific organization authorized to receive and use the information:
   North Atlantic States Carpenters Health Fund – Short Term Disability Representative(s)

3. Specific and meaningful description of the information:
   Description of information I authorize the Plan to disclose.
   a. Electronic and oral information related to eligibility for benefits commencing on _____ date of total disability.
   b. Written, electronic and oral information including claims, reports, and other documents related to claims for benefits for an injury or illness commencing on _____ date for which is a direct result of the need for me to access my Short Term Disability Benefits. These “other” documents may include, but will not be limited to: Details of my accident or injury; Right of Reimbursement Agreement; Auto Insurance Information related to PIP and or MedPay Benefits including payments and denials; Workers’ Compensation Insurance Information including payments and denials; or any other Insurance Information directly related to this disability claim which the Health Benefits Fund may already possess.

Authorization For Release of Protected Health Information (cont'd)

4. Purpose of the request:
   To avoid duplicate submission of information I may have already provided to the North Atlantic States Carpenters Health Fund, and which is directly related to my claim for Short Term Disability Benefits.

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

6. Right to Revoke:
   I understand that I have the right to revoke this authorization at any time by notifying the **Privacy Officer** in writing at 350 Fordham Road, Wilmington, MA 01887. I understand that the revocation is only effective after it is received and logged by the **Privacy Officer**. I understand that any use or disclosure made prior to the revocation under this authorization will not be affected by a revocation.

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

8. I understand that this authorization will expire 6 months from the date of my signature, or when the short-term disability benefits cease, whichever occurs first.

9. The Plan will not condition treatment, payment, enrollment, or eligibility for health plan benefits on receipt of an authorization. Exception: Except the North Atlantic States Carpenters Health Benefits Fund may condition eligibility for short-term disability benefits on this authorization, if this authorization is to allow the Fund to obtain the information it needs to make an eligibility determination and psychotherapy notes are not requested. If I refuse to sign this authorization I may be denied eligibility for short-term disability benefits.

I, _____(Please Print Name), have had an opportunity to review and understand the contents of this form. By signing this form, I am confirming that it accurately reflects my wishes.

_____ _____

Signature of Individual Date

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

_____