North Atlantic States Carpenters
Health Benefits Fund

Buffalo Office
1159 Maryvale Dr., Suite 20
Cheektowaga, NY 14225
Phone: (716) 839-7132
Toll Free: 1(877) 739-7136
Fax: (716) 839-7136
www.carpentersfund.org

South Central Office
181 Industrial Park Road
Horseheads, NY 14845
Phone: (607) 739-1326
Toll Free: 1(866) 727- 0281
Fax: (607) 739-1415
www.carpentersfund.org

PROTECTED HEALTH INFORMATION OR ANY INFORMATION RELATED TO THE FUNDS

AUTHORIZATION TO RELEASE INFORMATION

North Atlantic State Carpenters Health Benefits Fund

Dear Participant:

The Fund is hereby authorized to use or disclose claim information, membership information, benefit information, and medical records that contain Protected Health Information concerning myself, my spouse and dependent children under the age of 18, if applicable, (hereinafter collectively referred to as the "Undersigned") in connection with Fund eligibility for benefits, enrollment, treatment, payment of medical expenses and administration of the Fund. The North Atlantic States Carpenters Health Benefits Fund Employees are authorized to make such use and disclosure.

The disclosure may be made to any provider of medical services to the Undersigned, to the Board of Trustees of the Fund, to any third-party claims' administrator retained by the Fund in connection with the payment of any claim and/or appeal concerning the health benefits of the Undersigned and to my eligible dependents.

This authorization expires as to the respective Undersigned individual when such individual is no longer a Participant of the Funds or on date selected: _____ ***only complete if you have a specific date***
(mm/dd/yyyy)

The Undersigned understands that this authorization may be revoked by written notice to the Fund Office.

The Undersigned understands that the information used or disclosed pursuant to this Authorization may be subject to redisclosure by the recipient, and may no longer be protected by the federal or state privacy rules.

The Undersigned understands that the Fund will not condition enrollment in the Fund, eligibility for benefits or payment of benefits upon the providing of this authorization by the Undersigned.

The Undersigned have the right to inspect or copy the Protected Health Information used or disclosed pursuant to this Authorization upon submission of a written request to the Fund.

(over)

The Undersigned hereby authorize the release of Protected Health Information and any other specific information related to the funds and members accounts.

Participant's Signature _____ Date _____

Print Name _____ Last Four Social Security xxx-xx-_____

Print Authorized Representative's Name _____Date_____

Authorized Representative Signature_____ Pin Number_____

The Authorized Representative is the person you want to give permission to talk to North Atlantic States Carpenters Benefit Funds on your behalf. For example: balances in HRA, contributions and insurance information

DEPENDENT CHILDREN UNDER THE AGE OF 18 (If Applicable)

Name	**Date of Birth**	**Social Security Number**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____