



CARPENTERS SERVICES ADMINISTRATIVE CORPORATION

445 South Figueroa Street, Suite 1500
Los Angeles, CA 90071-3203

Tel: 213-386-8590 • Toll Free: 800-293-1370
csacbenefits.org

HIPAA Authorization Form

Your Name: _____ Birth Date: ____/____/____
Please Print (*your signature will be required below*) MM DD YY

Your relationship with Participant: Self Spouse Dependent Child

Address: _____

Home #: (____) _____ Work #: (____) _____ Cell #: (____) _____

Participant's Name: _____ Participant's SSN or UBC ID: _____

I hereby authorize the Western States Carpenters Health and Welfare Trust (the "Trust") to use and/or disclose my Protected Health Information as follows:

1. Information to be Used or Disclosed: The following Protected Health Information (PHI) may be used and/or disclosed as described below (*check those that apply*):

- Any health care information that you have about me
- Any information that relates to my eligibility for benefits provided by the Trust
- The dates of treatment that I received
- The reason(s) that I was denied benefits
- Other: _____

[Please describe the information so that it is specific and meaningful]

2. Persons to Whom the Use of Disclosure May be Made: The following person(s) or class of persons may receive the Protected Health Information described in Section 1 of this Authorization from the Trust and/or Carpenters Services Administrative Corporation (CSAC).

- Spouse's Name: _____
- Child(ren)'s Name(s): _____
- Parent's Name(s): _____
- Other Name: _____

[list the name or specific designation of the person or classes of persons]

If you only want your PHI released to someone who knows a password, provide your password here: _____

3. Purpose of the Request: Please state the purpose of the request below. If you do not wish to state a purpose, please enter: "At the request of the individual" _____

4. Expiration Date or Event: This authorization will expire (*choose and complete one*):

- Ten years from the date this authorization is signed
- On ____/____/____ (*less than 10 years from the date the authorization is signed*)
MM DD YY

Upon the occurrence of the following event(s) related to my health care or to the purpose(s) for which I have authorized the use and/or disclosure of my Protected Health Information: _____

I understand that:

- (1) I may revoke this Authorization in writing at any time except to the extent that the Trust has taken action in reliance on this Authorization;
- (2) The Trust may not condition treatment, payment, enrollment or eligibility for benefits on my willingness to sign this Authorization; and
- (3) Any information disclosed under this authorization may be subject to redisclosure by the recipient and may no longer be protected by law.

Signature: _____ **Date:** _____

Submit this completed form by mail to the address above or by fax at (213) 739-9463.