PENNSYLVANIA FACULTY
HEALTH AND WELFARE FUND

P.O. Box 60430
Harrisburg, PA 17106-0430

Telephone: (717) 233-4776

AUTHORIZATION FORM
Use or Disclosure of Protected Health Information

In order for the Pennsylvania Faculty Health and Welfare Fund to use or disclose your Protected Health Information to someone other than you, you must complete this Authorization Form and return it to the Fund. Protected Health Information ("PHI") is information that is created, received, transmitted or stored by the Fund relating to your past, present or future physical or mental health, health care or payment for health care, and either identifies you or provides a reasonable basis for identifying you. Except as permitted by law, the Fund may not use or disclose PHI to persons other than those you specify on this form. The Fund may request that you complete this form where the use or disclosure of information is necessary to carry out functions of the Fund. In addition, you may submit this form to the Fund because you want someone to request your PHI from the Fund. Print or type this form in full and make certain that it is properly signed.

Name of Faculty Member: _____

Name of Person for Whom Information Is Requested: _____

Relationship to Faculty Member: _____

Mailing Address: _____

_____

Telephone Number: _____

I authorize the Fund to disclose my PHI identified on the next page to the following persons:

Spouse: _____

Attorney: _____

APSCUF Representative: _____

Other Person(s): _____

Mailing Address of Person Authorized: _____

_____

Telephone Number: _____

I authorize the Fund to disclose my PHI (including written, electronic and/or oral information) to the persons identified above as specified on the next page of this form. If you want different people to have access to different information, you must fill out different forms.

All claims information for benefits covered by the Fund for the following: From_____ To_____

Dental claims for the following: From_____ To_____ Provider_____

Vision claims for the following: From_____ To_____ Provider_____

Supplemental claims for the following: From_____ To_____ Provider_____

A specific claim or inquiry as follows: _____

_____

_____

The purpose(s) for which the individual named on page one (1) may have access to the requested PHI:

_____

_____

This Authorization Form is valid for the period designated below (check one):

_____ For as long as I am eligible for benefits under the Fund.

_____ Until the following date or event:: _____

Read the following conditions carefully before signing this Authorization Form.

All parts of the Authorization Form must be completed in full. Sign the form and then make a copy for your records. **Mail the original signed copy to the Fund Office.** The Fund's mailing address is listed at the top of page one (1).

I understand that I am entitled to obtain a copy of this authorization from the Fund upon written request.

I have the right to refuse to sign this form, and my refusal to sign this form will not affect my ability to receive benefits from the Fund.

I understand that health information disclosed, resulting from this authorization, may be subject to re-disclosure. Health information, you authorize for release, is no longer protected by federal and state privacy laws.

I have a right to cancel this authorization at any time by submitting a signed letter of cancellation to the Fund (append a copy of this form to your cancellation).

Cancellation will take effect on the date or event noted above; the date a separate signed letter of cancellation is sent to the Fund; or the date the Fund receives notice of cancellation.

Dependent children over the age of 18 years of age must sign this form. Dependent children 18 years of age or younger must have a parent sign this form.

If the person signing this form is acting as the Personal Representative of the individual whose PHI is to be used or disclosed, you must provide legal proof of your authority to act for the person.

The person requesting use or release of PHI must sign below:

Signature: _____ Date Signed: _____

Print Name: _____ Birth Date: _____