



# Writers' Guild-Industry Health Fund

Terence L. Young, Chief Executive Officer

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## Authorization For Release of Information

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The Standards for Privacy of Individually Identifiable Health Information (the "Privacy Rule") under federal law requires certain protection and limitations on the disclosure of protected health information (PHI). PHI means information created or received by the Fund that identifies an individual and relates to the individual's past, present or future health, treatment or payment for health care services. PHI may include information regarding enrollment and eligibility.

In many cases, the Privacy Rule limits the Fund's ability to disclose PHI without appropriate authorization. While you are not required to grant an authorization, in certain circumstances, if you do not grant an authorization the Fund cannot disclose your PHI. In order to be valid, the authorization must include the beginning and end dates for the authorization. The authorization must also name the receiving individual/organization and provide a specific description of the information to be disclosed. You may name more than one individual or entity on this agreement only if they may all receive the same information. If each has authority to receive different information, separate authorizations are required.

Page 2 of this authorization requires the signature of the person authorizing the disclosure. Generally, this person must be the subject of the information to be disclosed. Alternatively, the individual's personal representative may authorize the disclosure.

If you wish to authorize disclosure, please carefully review and complete this authorization form and return it to the Fund Office.

### I. Information About the Use or Disclosure

**I hereby authorize the Fund to disclose certain individually identifiable health information (described in (A) below) to the persons in (B) below for the purposes described in (C) below.**

Name: \_\_\_\_\_ ID Number: \_\_\_\_\_

(If you are the participant's spouse, Same Sex Domestic Partner, or child, please also list the participant's name: \_\_\_\_\_)

A. Information to be used or disclosed: \_\_\_\_\_

Claims Status

Eligibility

Contributions

Other \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

B. Persons/organizations authorized to receive the information: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Producer-Writers Guild of America Pension Plan  
Writers' Guild-Industry Health Fund

C. Specific purpose of the disclosure: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

(If you don't want to describe your reasons, you may state "At the request of the individual.")

**This authorization is not valid if you do not complete (A)-(C).**

This authorization will begin on: \_\_\_\_\_  
Month Day Year

This authorization will expire (choose one):

On \_\_\_\_\_  
Month Day Year

Upon the occurrence of the following event: \_\_\_\_\_  
\_\_\_\_\_

This authorization shall expire no later than one year from the date of execution.

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## II. Important Information About Your Rights

I have read and understood the following statements about my rights:

- I may revoke this authorization at any time prior to its expiration date by notifying the Fund Office in writing, but the revocation will not have any effect on any actions the Fund took before the Fund received the revocation.
- The information that is used or disclosed pursuant to this authorization may be redisclosed by the receiving entity without my authorization.
- I understand that I am not required to sign this form to receive my health care benefits, although I must complete all applicable forms for benefits.

## III. Copy of this Authorization

- You are entitled to a copy of this authorization. If you do not want the Fund to send you a copy, please check this box .

## IV. Signature

\_\_\_\_\_  
**Signature of individual or personal representative**  
(Form *MUST* be completed before signing.)

\_\_\_\_\_  
**Date**

Printed name of personal representative: \_\_\_\_\_

Relationship to the individual, including authority for status as representative: \_\_\_\_\_  
(Please provide proof of your status as the individual's personal representative.)