PWGA
Pension & Health Plans
YOUR TRUSTED GUIDE

Authorization for Use/Disclose Protected Health Information (PHI)

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.

The Plan will not use or disclose your protected health information without your Authorization except as described in the Plan's Notice of Privacy Practices. If you want the Plan to use or disclose your protected health information in a way that requires your Authorization, complete this Authorization form and submit it as instructed below. *This Authorization is not valid without your dated signature.*

THIS AUTHORIZATION MUST BE COMPLETED IN FULL FOR IT TO BE VALID

I. Information about the Use or Disclosure

Name:_____ ☐ Participant ☐ Spouse ☐ Domestic Partner ☐ Child

Participant Name:_____ Participant ID#: _____

I hereby authorize the Fund to disclose certain individually identifiable health information to the following person below for the purposes described below.

Name & Organization *(if applicable)* (If organization, attach a listing of personnel authorized to receive disclosed information)	
Relationship or Title	
Address	
City, State & Zip	
Phone Number	

A. Information to be used or disclosed:

ALL health information related to ☐ Claim Status ☐ Eligibility ☐ Contribution

OR

Release only the following specific information: *(Check all applicable boxes)*

☐ All of my health information from _____ through _____.
(Month/Day/Year) *(Month/Day/Year)*

☐ All of my health information relating to my treatment for _____
(Condition)
from _____ through _____.
(Month/Day/Year) *(Month/Day/Year)*

☐ All of my health information relating to my treatments provided by _____
(Provider of Service)
from _____ through _____.

☐ Other (be specific as possible) _____

_____

This Authorization will begin on _____ (effective date) and will remain in effective until _____ (expiration date or event).

This Authorization shall expire no later than two years from the date of execution. You may revoke this Authorization at any time earlier than the expiration date or event by writing to the Plan at the following address:

Writers' Guild-Industry Health Fund
Attention: Privacy Official
2900 W Alameda Ave Suite 1100
Burbank, CA 91505

Revocation forms are available upon request from the above address. If you revoke your Authorization, the Plan will no longer disclose your protected health information except as described in the Plan's Notice of Privacy Practices or as permitted under your remaining Authorizations, if any. I understand that the revocation will not be effective until I receive written confirmation from the Fund.

II. Important Information About Your Rights

I hereby authorize the Plan to use and disclose my protected health information in accordance with this Authorization. I understand that protected health information disclosed in accordance with this Authorization may be re-disclosed by the recipients listed in this Authorization and, as a result, may no longer be protected under applicable health privacy laws or under the Plan's privacy practices. I understand that, without my Authorization, the Plan may use my protected health information only as described in the Plan's Notice of Privacy Practices or as permitted under my remaining non-revoked Authorizations, if any. I understand that I am not required to sign this form to receive my health care benefits.

This Authorization is made at my request. I understand that payment of my Plan claims and eligibility for my Plan benefits are not affected by my decision to complete this Authorization form.

I understand that this Authorization is valid until the revocation date indicated above, or until I revoke this Authorization in writing (but no longer than two years). I understand that I have the right to revoke this Authorization at any time, except to the extent that the Plan has already used or disclosed my protected health information in reliance on the Authorization.

Signature _____ Date _____

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 ☐ .