EIT BENEFIT FUNDS
SERVING THE CHICAGO ELECTRICAL INDUSTRY SINCE 1930

Authorization to Release Protected Health Information

1. Participant Information: *The Participant is the employee (the insured).*

Participant Name:	**SSN:**	**Birth Date:**
Street Address:		**Apt #:**
City:	**State:**	**Zip Code:**
Home Phone: ( )	**Cell Phone: ( )**	
Employer Name:		

☐ ***Participant is the Patient*** *(If checked, please go to Section 3 below)*

2. Patient Information: *The Patient is the person giving permission for their Health Information to be released.*

Patient Name:	**Relationship to Participant:**	
Birth Date:		**Age:**
Patient's Address:		**Apt #:**
City:	**State:**	**Zip Code:**
Home Phone: ( )	**Cell Phone: ( )**	

3. Person/Organization Receiving Information: *Only one person or organization per Authorization*

Person or Organization Name:	**Relationship to Patient:**	
Person or Organization Address:		
City:	**State:**	**Zip Code:**
Telephone: ( )		

4. Information To Be Released: *I authorize the following information to be released (check ✓all that apply).*

☐ All Health/Medical Related Information ☐ Appeal ☐ Claims ☐ Eligibility

☐ Other *(must specify if you choose "other")*: _____

5. Purpose of Use/Disclosure: *This Authorization is for the following purpose (check ✓ only **one** of the choices).*

☐ Continuing Medical Care ☐ Disability ☐ Insurance ☐ Legal Purposes

☐ Personal Use ☐ Other *(describe)*: _____

6. Patient Authorization: *The PATIENT (or legal guardian) must sign and date the Authorization to make it valid.*

I hereby authorize the use or disclosure of the protected health information described above by the person or organization listed above. I understand that EIT Benefit Funds cannot control the information after it is released. I understand that this request may include any reports, correspondence, test results, diagnosis or medical procedures. I understand that, once approved, this authorization will remain in effect unless I revoke it. I further understand that I can revoke this Authorization at any time by notifying EIT Benefit Funds' Privacy Officer in writing, but revoking this Authorization will not affect information already released. If I revoke this Authorization, additional information will not be released, except where permitted or required by law. If I do not sign this Authorization form, my ability to obtain treatment, payment or, eligibility for benefits with EIT Benefit Funds does not change. I certify that I have read the Plan's HIPAA Privacy Notice and understand my rights.

Patient Signature: _____ **Date:** _____
(or Legal Guardian)

Print Name: _____ **Relationship to Patient:** _____
(if Legal Guardian)

Return your completed Authorization to:

EIT BENEFIT FUNDS • 6195 West 115th Street, Alsip, IL 60803 • Phone (312) 782-5442 • Fax (312) 782-4431 • www.fundoffice.org