NORTHERN CALIFORNIA PIPE TRADES ("NCPT") TRUST FUNDS FOR UA LOCAL 342

AUTHORIZATION FOR RELEASE OF INFORMATION (INCLUDING PROTECED HEALTH INFORMATION)

Note*: *The execution of this Authorization does not authorize release of information other than that specifically described below.

SECTION I. INFORMATION ABOUT THE USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION ("PHI") AND RETIREMENT BENEFIT INFORMATION

Participant/Retiree/Dependent/Alternate Payee Name:_____Social Security No. xxx-xx-_____

Email Address: _____ Date of Birth: _____

I hereby authorize the use or disclosure of my written, electronic, and oral benefit information as described below.

1. **Specify the individual/organization ("Recipient") authorized to receive your benefit information (e.g. Spouse, Parent, etc.) and also check the box(es) immediately below the Recipient's name to specify the Fund(s) you are authorizing release of information on.**

Recipient Name:_____ Phone Number (_____)_____

Relationship*:_____ Email Address:_____

❒ FOR Protected Health Information ("PHI") from the NCPT Health and Welfare Trust Fund.

❒ FOR Retirement Benefit Information from the NCPT Pension Trust Fund.

Recipient Name:_____ Phone Number (_____)_____

Relationship*:_____ Email Address:_____

❒ FOR Protected Health Information ("PHI") from the NCPT Health and Welfare Trust Fund.

❒ FOR Retirement Benefit Information from the NCPT Pension Trust Fund.

** Any change in life circumstances that alters the relationship you have listed may invalidate this authorization.*

2. **Check the applicable box(es) to specify the NCPT Plan(s) authorized to provide information:**

❒ NCPT Health and Welfare Trust Fund and/or NCPT Pension Trust Fund
(*This applies without restriction, only to benefits administered at the Trust Fund Office.*)

❒ Specify if limiting authority:_____

3. **Check the applicable box to describe the information you authorize the Trust Fund Office Staff to disclose:**

❒ All benefit matters including, but not limited to, eligibility, pension, claims for benefits, dues statements, appeals of the denial of benefits, financial information, and any other indebtedness or obligation incurred by Participant or on the Participant's behalf; **or**

❒ If limiting authority, specific circumstance, or limited information to be disclosed:_____

4. **The purpose of this request:**

❒ To discuss benefits with the Trust Fund Office so I can better understand my benefits; **and/or**

❒ Other: _____

5. **This authorization will expire on:**

❒ Indefinitely; **or**

❒ Specified Date: _____

SECTION II. IMPORTANT INFORMATION ABOUT YOUR RIGHTS – I have read and understand the following statements about my rights:

- I understand that this authorization is voluntary.
- I understand that I have the right to revoke this authorization at any time by notifying the Trust Fund Office in writing. I understand that the revocation is only effective after it is received and processed by the Trust Fund Office. I understand that any use or disclosure made prior to the revocation under this authorization will not be affected by a revocation.
- I understand that after information is disclosed, federal law might not protect it and the recipient might disclose it again. I further understand if the recipient I have authorized to receive the information is not a health care provider or health plan, the released information may no longer be protected by federal privacy regulations.
- I understand that the Trust Fund Office will not be held responsible for the release and subsequent use of information.
- I understand that I am entitled to receive a copy of this authorization. (Please retain a copy for your records.)
- I understand the Plan will not condition enrollment, eligibility, or payment of benefits on receipt of an authorization.
- I understand that if I have authorized my spouse to receive information, this authorization will be invalidated upon notification to the Trust Fund Office of a separation in any form (including legal separation or unofficial separation where you no longer live with your covered spouse) or divorce.
- I understand that this authorization supersedes and overrides any previous authorization(s) I have submitted.

The refusal to sign this authorization will not affect any entitlement, according to the Plan's provisions, to receive payment of benefits or eligibility for benefits unless authorized by law. All member documents and personal information are strictly confidential and will not be shared with others without your authorization. The Authorization for Release of Information allows the Trust Fund Office to release specific information authorized by you to another person or organization.

I DECLARE UNDER PENALTY OF PERJURY THAT THE INFORMATION ON THIS FORM IS TRUE AND CORRECT.

III. SIGNATURE (PARTICIPANT/RETIREE/DEPENDENT/ALTERNATE PAYEE):_____

Date:_____

SECTION IV. Authorized Personal Representative (This section must be completed if applicable.):

First name: _____ Last Name: _____

Email address: _____ Telephone: _____

Address: _____ City: _____ State: _____ Zip Code:_____

Legal Authority You Have to Receive Information (***You must attach legal documentation to verify that you are the authorized representative for the individual***).

_____ Parent of Minor _____ Conservator _____ Guardian _____ Medical Power of Attorney _____ Executor of Will

_____ Administrator of Estate _____ Other (If other please indicate: _____)

Return completed Form to: Kim Biagi
NCPTTF Privacy Officer
935 Detroit Avenue, Suite 242A
Concord, CA 94518-2501

Phone 925/356-8921
Fax: 925/356-8938
Email: *tfo@ncpttf.com*
Website: *www.ncpttf.com*

INSTRUCTIONS FOR COMPLETION OF THE AUTHORIZATION FOR RELEASE OF INFORMATION

Completion of this Authorization is required if you wish to permit the Northern California Pipe Trades Health and Welfare Trust Fund and/or Northern California Pipe Trades Pension Trust Fund to release your information (including Protected Health Information) to another person or organization.

Please refer to these instructions to help answer any questions you may have when completing this Authorization for Release of Information.

SECTION I	Individual Authorizing the Release of Information. List your full name and the last four (4) digits of your Social Security Number.
Item 1	Individual (or Organization) you are permitting to receive your information. • List the name(s) of the individual(s) or organization(s) (the "Recipient") along with their phone number, relationship to you, and, email address. • Designate the Plan(s) that you are authorizing to release information by placing a check mark by the Plan name.
Item 2	Limitations on release of information. You can either permit the Plan(s) to release information without restriction or you can specify any limits to the type or kind of information that may be released to the individual(s) or organization(s) that you permitting disclosure of information. Note: If authorizing release of Protected Health Information ("PHI"), it is defined as individually identifiable medical, mental health/substance abuse, and genetic information that relates to your physical or mental health condition, the provision of health care to you, or payment of such health care.
Item 3	Limitation on the type of information that may be released. You can either permit the Plan(s) to release all information or you can limit the circumstances in which information may be released or limit the type of information that may be released.
Item 4	Reasons for Release of Information. Specify the reason you are permitting release of information to the individual(s) or organization(s) you have designated.
Item 5	Length of time that your Authorization for Release of Information is valid. You can either request that the authorization remain in effect indefinitely or specify a time limit. This section must be filled out to authorize a release of information.

SECTION II	Information about your Rights. You should carefully read this section and, if you have any questions, contact the Trust Fund Office.

SECTION III	Signature of the Individual Authorizing the Release of Information. You must sign and date the Authorization.

SECTION IV	Authorized Personal Representative. If you are completing this Authorization as the Authorized Personal Representative of the Participant/Retiree/Dependent/Alternate Payee named on this Authorization, you must complete this section in full. In addition, you must provide legal documentation to verify that you are the Authorized Representative that has authority for the Participant/Retiree/Dependent/Alternate Payee named.

You can designate up to two (2) individuals or organizations that you are permitting the Plans to release information to on this Form. If you want to designate more than two (2) individual(s) or organization(s), you will need to complete another Authorization for Release of Information.