LAKE COUNTY INDIANA N.E.C.A. – I.B.E.W.
HEALTH & BENEFITS PLAN

Authorization to Use or Disclose Health Information

Name of Member/Dependent: _____

Social Security No.:_____ Date of Birth: _____

I authorize:_____ _____
Name Phone Number

_____ _____
Name Phone Number

_____ _____
Name Phone Number

_____ _____
Name Phone Number

to act in my stead to obtain the above named individual's health information as described below.

1. I authorize: **Lake County Indiana NECA-IBEW Health & Benefit Plan** to disclose the above named individual's entire health care information to the aforementioned.

2. This information for which I am authorizing disclosure will be used for the following action obtaining medical information of any and all matters involving my health or healthcare including but not limited to records and billings. The type of information to be used or disclosed may include: health records which may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome, (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

3. I understand that I may revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing. I understand that the revocation will not apply to information that has already been released pursuant to this authorization.

4. I understand that once the above information is disclosed, it may be redisclosed by the recipient and the information may be protected by federal privacy laws or regulations.

5. I understand that authorizing the use of disclosure of the information identified above is voluntary.

_____ _____
Signature of Member/Dependent/Legal Representative Date

_____ Seal:
Notary Public

Subscribed and sworn to before me on:_____

Note: This form was developed in compliance with the legal requirements of HIPAA.

Mail completed form to: 7200 Mississippi St, Suite 300, Merrillville, IN 46410