Authorization Form

The Plan will not use or disclose your protected health information without your Authorization. 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 (or your Personal Representative's) dated signature.

Your name:_____ Your birth date:_____

Requestor's name:_____ Relationship to you:_____
(if form is completed by your Personal Representative)

Covered Employee's name: _____ Covered Employee's SSN:_____

I authorize the Plan to use or disclose my following protected health information in accordance with this Authorization:

All of my health records from _____ through _____.
start date end date

All of my health records relating to my treatment for _____
specific diagnosis or treatment

_____ from _____ through _____.
start date end date

All of my health records relating to my treatments provided by _____
doctor/health care provider's name

_____ from _____ through _____.
start date end date

Other (be as specific as possible) _____

_____

I authorize the Plan to use or disclose my protected health information for the following purposes:

_____

_____

Please provide the name and contact information for each person or entity to whom the above protected health information may be disclosed, if applicable. Attach additional sheets, if necessary. Please note – once your protected health information is disclosed to these persons or entities, the Plan cannot prevent the redisclosure of your information by such persons or entities.

Name of Person/Entity	Name of Person/Entity
Street	Street
City State Zip Code	City State Zip Code

Authorization Form

This Authorization is effective until _____ (if you do not select an expiration date, your Authorization will remain in effect for 1 year or until revoked by you in writing). You may revoke this Authorization at any time by writing to the Plan at the following address:

Airconditioning and Refrigeration Industry
Health and Welfare Plan
3500 W. ORANGEWOOD AVENUE
ORANGE, CALIFORNIA 92868
Fax: (714) 917-6065

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.

Read and sign the following statement:

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 permitted under my remaining non-revoked Authorizations, if any.

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. 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 this Authorization.

Signature:*_____ Date:_____

**If you are making this request on behalf of another individual, a completed Personal Representative form must be on file with the Plan unless the individual is your minor child or ward and you also participate in the Plan.*

Send this completed Authorization form to the Plan at:

Airconditioning and Refrigeration Industry
Health and Welfare Plan
3500 W. ORANGEWOOD AVENUE
ORANGE, CALIFORNIA 92868
Fax: (714) 917-6065

If you have questions about this Authorization form, contact the Plan at (714) 917-6100.

For internal use only:
Date received:_____ Date revoked:_____