Airconditioning and Refrigeration Industry Health and Welfare Trust
Authorization Form

The Airconditioning and Refrigeration Industry Health and Welfare Trust ("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 (or your Personal Representative's) dated signature.

Participant's name:_____ Participant's birth date:_____

Requestor's name:_____Relationship to Participant:_____

If form is completed by the Power of Attorney as Agent or Executor, a complete copy of the Power of Attorney must be submitted. If form is completed by a Personal Agent, a copy of the applicable court order must be submitted.

Phone Number: (_____)_____ Participant's ID or Last Four 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 _____ (start date) through _____ (end date).

☐ All of my health records relating to my treatment for: _____ (specific diagnosis or treatment)

_____ from _____ (start date) through _____ (end date).

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

_____ from _____ (start date) through _____ (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
(_____) _____ Contact phone#	(_____)_____ Contact phone#

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This Authorization is effective until _____ [expiration date] (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:

Privacy Officer
Airconditioning and Refrigeration Industry
Health and Welfare Plan
3500 W. Orangewood Avenue
Orange, CA 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 redisclosed 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.

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 or complete copy of the Power of Attorney 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:

Privacy Officer
Airconditioning and Refrigeration Industry
Health and Welfare Plan
3500 W. Orangewood Avenue
Orange, CA 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:_____