**SOUTHERN CALIFORNIA IBEW-NECA TRUST FUNDS**
**PARTICIPANT AUTHORIZATION FORM**

Participant Name: _____ Birth Date: _____/_____/____
MM / DD / YR

Address: _____
_____
_____

Home Telephone Number: _____ E-mail: _____
Work Telephone Number: _____

Participant Identification Number and/or Social Security Number: _____

By signing this authorization form I authorize the person(s) and/or organization(s) described below to use and/or disclose my health information (information that constitutes protected health information as defined in the Privacy Rule of the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996) in the manner described below. I understand that I am under no obligation to sign this form. The person(s) and/or organization(s) described below who I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization, except as follows:

- A health plan may condition enrollment in the health plan or eligibility for benefits on this authorization if I am not yet enrolled in the health plan, the purpose of this authorization is to allow the health plan to obtain the information it needs to make an eligibility, enrollment, underwriting or risk rating determination and psychotherapy notes are not requested. If I refuse to sign this authorization I may be denied enrollment in the health plan or eligibility for health care benefits.

I have signed this form voluntarily to document my wishes regarding the use and/or disclosure of the health information described below in Section 1 of this form.

1. Description of Health Information I Authorize to be Used or Disclosed. The following is a specific description of the health information I authorize be used and/or disclosed: (Specify and provide a meaningful description.)

_____
_____
_____

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2. Persons/Organizations Authorized to Use and/or Disclose My Health Information.
I authorize the following person(s) and/or organization(s) (or classes of persons and/or organizations), including [Health Plan], to use and/or disclose the health information described above in Section 1 of this form.

_____

_____

_____

3. Persons/Organizations Authorized to Receive and/or Use My Health Information.
I authorize the following person(s) and/or organization(s) (or classes of persons and/or organizations) to receive my health information from the person(s) and/or organization(s) described in Section 2 above and to use or disclose such information for the purposes listed below in Section 4 of this form. I understand that if the person(s) and/or organization(s) listed below are not health care providers, health plans or health care clearinghouses subject to federal privacy standards, the health information disclosed pursuant to this authorization may no longer be protected by the federal privacy standards and such person(s) and/or organization(s) may re-disclose my health information without obtaining my authorization.

_____

_____

_____

4. Description of Each Purpose for the Requested Use and/or Disclosure. I authorize my health information to be used and/or disclosed for the following specific purposes:

_____

_____

_____

5. Your Rights with Respect to This Authorization.

5.1 Right to Revoke. I understand that I have the right to revoke this authorization at any time. I also understand that my revocation of this authorization must be in writing. To obtain a copy of an authorization revocation form I may contact the Privacy Officer at 515 South Avenue 19, Los Angeles, California 90031; telephone (323) 221-5861. I am aware that my revocation will not be effective as to uses and/or disclosures of my health information that the person(s) and/or organization(s) identified in Sections 2 and 3 of this form have already made in reliance upon this authorization.

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5.2 Right to Receive Copy of This Authorization. I understand that if I agree to sign this authorization, which I am not required to do, I must be provided with a signed copy of it.

6. Disclosure of Direct or Indirect Remuneration Received By Any Person or Organization Authorized to Use or Disclose My Health Information. I understand that the following person(s) and/or organization(s) will be receiving direct or indirect remuneration in connection with the use or disclosure of my health information:

_____

_____

_____

7. Expiration of Authorization. This authorization will expire (choose and complete one):

☐ On _____/_____/_____.
MM / DD / YR

☐ Upon the occurrence of the following event(s) related to my health care or to the purpose(s) for which I have authorized the use and/or disclosure of my health information described in Section 4 of this form:

_____

_____

_____

I, _____ (please print name), have had an opportunity to review and understand the contents of this form. By signing this form, I am confirming that it accurately reflects my wishes.

_____ _____/_____/_____
Participant Signature Date

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If signed by a personal representative, complete the following:

Name of personal representative: _____

Relationship to participant or nature of authority (e.g., health care power of attorney, guardian, other statutory authorization): _____

Address: _____
_____
_____

Home Telephone Number: _____ E-mail: _____
Work Telephone Number: _____

_____ _____/_____/_____
Signature of Personal Representative Date