TOLEDO ELECTRICAL WELFARE FUND
HIPAA AUTHORIZATION FORM

Patient's Full Name	**Patient's Social Security Number/Medical Record Number**
Address	**Patient's Date of Birth**
City, State Zip Code	**Patient's Telephone Number**

I hereby authorize the Toledo Electrical Welfare Fund to disclose my Protected Health Information to the person or entity described below:

1. The following person (or class of persons) may receive disclosure of protected health information about me:

   Name

   Address

   City, State Zip Code

2. The specific information that should be disclosed is (please give dates of service if possible):

_____

_____

_____

3. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations.
4. I may revoke this authorization at any time by notifying the Toledo Electrical Welfare Fund in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.
5. I understand that treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.
6. This authorization expires on _____, 20___, OR upon occurrence of the following event that relates to me or to the purpose of the intended use or disclosure of information about me: _____.

THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING

_____	_____	_____
Signature of Individual* (The person about whom the information relates)	**Date of Individual's Signature**	**Date of Birth or Social Security Number**
OR, if applicable –		
_____	_____	_____
Signature of Guardian* or Personal Representative of Patient's Estate	**Date of Guardian's/Personal Representative's Signature**	**Description of Authority to Act for the Individual**

A copy of this completed, signed and dated form must be given to the Individual or other signator.

Official Use Only	
_____	_____
Received	**Processed By**