MEMORANDUM

To: All Participants

From: Board of Trustees

In order to comply with HIPAA Privacy Regulations (45 CFR Part 160 and Subparts A & E of Part 164 and 164.502(b), 164.514(d), 164.502(6)) the attached Declaration regarding Disclosure of Protected Health Information must be signed.

- To enable your spouse to call and obtain the minimum necessary information relevant to your spouse's involvement in your health care.
- A separate Declaration must also be signed by any dependent over the age of 18 to enable you or your spouse to call and obtain information relevant to their health care.
- To enable your ex-spouse to call and obtain the minimum necessary information relevant to your ex-spouse's involvement in your dependent children's health care.

This document is designed to be utilized prospectively to reflect an intention that certain information relevant to payment may be disclosed to persons who are involved in payment. This form is primarily useful to inform the Fund that a participant wishes a spouse/dependent to speak to the Fund Office regarding a claim. It is not an Authorization which would permit full disclosure, but whose coverage would be limited. Rather, it is a blanket permission to disclose to a person such as a spouse minimum necessary information relevant to the person's involvement in the participant or beneficiary's health care. However, it should be noted that the Fund remains free not to honor the form if it subjectively learns of information which would lead the Fund to believe that disclosure would not be in the participant or beneficiary's best interests.

If you have any questions, please contact the Fund Office at 630-887-4150.

Sincerely,

Board of Trustees

Teamsters Local 731 Welfare Fund

DECLARATION REGARDING DISCLOSURE OF PROTECTED HEALTH INFORMATION TO DESIGNATED PERSONS INVOLVED WITH MY HEALTH CARE OR PAYMENT FOR HEALTH CARE

Name:_____ Birth Date:____/____/_____
Member / Employee Name MM DD YYYY

Address: _____

_____

_____

Home Telephone Number:_____ E-mail:_____

Work Telephone Number:_____ PIN: _____

Identification Number and/or Social Security Number: _____

Participant I.D. and/or Social Security No. (if different) _____

By signing this declaration form I declare and identify the <u>following person(s)</u> as persons to whom the Teamsters Local 731 Health and Welfare Fund may disclose my health records in addition to the following records listed below:

Name (s) _____

Relationship to Member _____

This declaration is not a formal "authorization" as defined in the Privacy Rule of the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996, but represents an aid for the Fund, in its professional judgment, to identify those persons to whom such disclosure would be in my best interests. The Fund may rely upon this declaration until I revoke the declaration or the Fund subjectively learns of circumstances which lead the Fund, in its professional judgment, to determine that disclosure is no longer in my best interests. This declaration shall not preclude the Fund from determining, pursuant to the standards set forth in the Privacy Rule of the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996, that disclosure to persons not identified above may also be permitted based upon their involvement in my health care or in

-Over-

payment for my health care. I also understand that, pursuant to the Privacy Rule of the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996, a parent or guardian of an un-emancipated minor child, to the extent permitted and subject to the limitations set forth in the Privacy Rule, shall be provided access to protected health information concerning the un-emancipated minor child.

I, _____, have had an opportunity to review and
Member / Employee Name (Please Print)
understand the contents of this form. This authorization is only valid through _____/_____/_____. I understand that if I wish to extend this authorization, I must submit
MM DD YYYY
a new authorization to the Fund office at such time as this one expires. By signing this form, I am confirming that it accurately reflects my wishes.

_____ Date: ____/____/_____
Member / Employee's Signature MM DD YYYY

If signed by a personal representative, complete the following:

Name of personal representative: _____

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

Address: _____

_____

_____

Home Telephone Number:_____ E-mail:_____

Work Telephone Number:_____ PIN: _____

_____ Date: ____/____/_____
Signature of Personal Representative MM DD YYYY