UNITE HERE LOCAL 11 | Health Benefit Fund

Authorization for Release of Protected Health Information

Fill out completely to prevent delay.

For help:
Phone: (866) 345-5189
Email: help@benefits11.org

Submit form:

Mail: Unite Here Local 11 Health Benefit Fund
1122 W. Washington Blvd, Suite 300
Los Angeles, CA 90015

Check one:
☐ I am the employee *(I get insurance coverage through my job)*
☐ I am a dependent *(I am in the employee's family and he/she provides my coverage)*

1: Employee Information

Last Name	First Name	Middle Initial	Date of Birth (mm/dd/yy)	SS # or Member ID #	Phone

Street	Apt #	City	State	Zip

2: Dependent Information

Full Name	Relationship to Employee	Date of Birth	Age	Phone

Street	Apt #	City	State	Zip

What is the purpose of this authorization? *(Check one)*:

☐ At my request ☐ For a different purpose _____

I want Unite Here Local 11 Health Benefit Fund (the Fund) to discuss and/or release ☐ **my** or ☐ **my dependent's** health information to the following person or organization:

Person/organization _____ **Phone Number** _____

Relationship to me (my sister, doctor, lawyer, etc.): _____

I want the Fund to release the following information to the person or organization named above (check all that apply):

☐ ANY and ALL information ☐ Explanations of Benefits ☐ Appeal ☐ Itemization of Lien
☐ Other _____

Choose method of delivery, if applicable, (provide number/address):

☐ By mail to: _____
☐ By fax to: _____ ☐ By email to: _____

I want this authorization to expire (check one):

☐ Not until I revoke ☐ On this date (Please specify): _____
☐ When the following event occurs: _____

If I do not check a box, this authorization will expire in one year.

I, _____ , authorize the use or disclosure of health information as described above. I have read and understand the contents of this form. I understand that the Fund cannot control information after it is released. I understand that I can revoke (cancel) this Authorization at any time by notifying the Fund's Privacy Officer in writing, but revoking will not affect information already released. If I revoke this Authorization, additional information will not be released, except where permitted or required by law. I am signing this form voluntarily. If I do not sign this Authorization, my ability to obtain treatment, payment, enrollment, or eligibility for benefits with UNITE HERE HEALTH does not change. ***By signing and dating this form, I am allowing the Fund to share my/my dependent's health information with the person or organization named above.***

3: REQUIRED Signature and Date

Signature of the person authorizing release of health information	Date

Print Name	Relationship to Employee	State	Zip

For Office Use Only	Date Received	Received By	Copy Mailed On	Copy Given to Patient On