

**Alaska Electrical Health & Welfare Fund**  
**2600 Denali Street, Suite 200**  
**Anchorage, AK 99503**  
**(907) 276-1246 • (800) 478-1246 • FAX (907) 278-7576**

**AUTHORIZATION FOR USE OR  
DISCLOSURE OF HEALTH INFORMATION**

Identify below, the individual whose protected health information will be disclosed:

Individual's name	Individual's social security number	Individual's daytime phone
Mailing Address	City	State      Zip Code
Participant's name (If different than Individual's)	Participant's social security number	Relationship to participant

**PURPOSE OF AUTHORIZATION**

This Authorization is required for your Health Plan to release your health information to someone other than yourself or for purposes outside the Health Plan's normal operations (treatment, payment of claims or healthcare operations). The recipients of this Authorization will rely on it to disclose your health information. Please review it carefully.

**STATEMENT OF RIGHTS REGARDING THIS AUTHORIZATION**

General Rights. I understand I am not required to sign this form and that a Covered Entity receiving it cannot condition treatment, payment or eligibility on my decision to sign this form. I understand, however, that a health plan can condition enrollment in the Plan or eligibility for benefits on receiving an authorization if the purpose is to allow the health plan to obtain information it needs to make an eligibility, enrollment or underwriting decision and psychotherapy notes are not requested.

Right to Revoke. I understand that I have the right to revoke this authorization in writing except as to uses and/or disclosures already made in reliance on it. Authorization revocation forms can be obtained by contacting the Contact Person listed in my Health Plan's Privacy Notice.

Effect of Disclosure. I understand that if the persons to whom my health information is disclosed are not subject to the HIPAA Privacy Rule (i.e. are not a health plan, health care provider or health care clearinghouse), the disclosed health information may no longer be protected by the HIPAA Privacy Rule and may be redisclosed without my authorization.

Retention and Right to Copy. I understand that a Covered Entity which receives this Authorization must retain a copy and that I am required to receive a signed copy as well.

Provisions Related to Psychotherapy Notes. I understand that an Authorization is required for any use or disclosure of psychotherapy notes except in the limited situations dealing with treatment, training or defense of legal actions as defined in 45 CFR 164.508(a)(2).

**NATURE OF DISCLOSURE BEING AUTHORIZED**

The information requested in Questions 1 through 6 **must** be provided for this Authorization to be effective.

1. **Describe Health Information To Be Disclosed** Identify below what health information you authorize to be used or disclosed. The description should be specific such as "Information related to my knee surgery":

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