Operating Engineers Local #139 Health Benefit Fund
Authorization to Release Protected Health Information (PHI) By the Fund

Name of 139 Member _____ OEF or SSN_____

You MUST complete all of the information requested on this form for your authorization to be valid.

I authorize the Fund to disclose my Protected Health Information (PHI) as described in this authorization. I understand the Fund may not determine my treatment, payment, enrollment or eligibility for benefits on whether or not I give the authorization listed in this form.

1. **The Fund can release PHI to:** The Fund is authorized to release the PHI described below to the following person(s) or organization:

   - ☐ My Parents (Please list names):_____
   - ☐ My Spouse (Please list name):_____
   - ☐ Other (List full names):_____

2. **The information that may be used or released is:**

   - ☐ All Information held by the Fund concerning my eligibility, benefits, claims decisions and payments.
   - ☐ Other: Please specify what to disclose below.

     _____
     _____

3. **Right to revoke:** I understand that I have the right to revoke this authorization at any time by notifying the Fund Office in writing at the address listed below. I understand that the revocation is only in effect after it is received and logged by the Fund. I understand that any use or disclosure made prior to the revocation under this authorization is not a violation of my privacy.

4. **Re-Release of information:** I understand that after this information is released, federal law might not protect it and the recipient might re-release it. I also understand and agree not to hold the Fund and any of its agents liable if the information is re-released.

5. **Validity of form:** This form is valid until the earliest of the following:

   - ☐ The date the Fund receives my cancellation form.
   - ☐ Other: _____

6. **Acknowledgement and signature:** I understand that I have the right to refuse to sign this authorization form.

Signature: _____ Date:_____

Print your name: _____ Telephone #:_____

Address of Dependent: _____

Mail or Fax completed forms to: Operating Engineers Health Benefit Fund, PO Box 160, Pewaukee, WI 53072