Instructions for Completing an Authorization Form

How to authorize the Culinary Health Fund's disclosure of an individual's protected health information to a person or organization

IMPORTANT - You must fill out all of the numbered sections of the form. If you do not, the form will be returned to you for completion. If any of the information you provide does not match the Fund's records, the Authorization may be returned to you for more information.

1. **Participant Information - *the Participant is the employee (the insured)***

   Print the Participant's social security number, name, date of birth, address and phone number. The information on the Authorization will be compared to information at the Fund Office to verify the identity of the Participant.

2. **Patient Information - *the Patient is the person who is giving permission for their health information to be released.***

   Print the Patient's name, date of birth, address, phone number and their relationship to the Participant. If the Participant is the Patient, you can check the box beside "Patient is the Same as the Participant", and you do not have to fill out the remaining information in Section 2. The information on the Authorization form will be compared to information at the Fund Office to verify the identity of the Patient.

3. **Person or Organization Receiving the Information**

   Print the name of the person or organization you (the patient) are authorizing the Fund to share your health information with.

4. **Information To Be Released**

   Check the boxes provided for the types of information to be released. You can check more than one box. If you are allowing "any and all" information to be released, check the box marked "Any and all information". Check "other" if you want to be more specific about the information to be released, for example:
   - Information on treatment by Dr. Smith from May 1, 2002 to May 5, 2002;
   - The claims payment for all care from March 31, 2002 through April 15, 2002; or
   - The reasons for the denial of benefits for services provided on June 24, 2002 at the XYZ clinic.

5. **Purpose of Use/Disclosure**

   Write a short description of the reason for the authorization (example: "need help with claims").

6. **Expiration of the Authorization**

   You must provide an expiration date of when the Authorization will expire. If you do not provide a date, the Authorization will expire one year from the date it is signed by the Patient (or legal guardian).

7. **Signature and Date**

   The Patient (the person listed under #2) must sign and date the form or it will be considered invalid. If the patient is a minor, the form should be signed by a custodial parent or legal guardian. If the form is signed by a legal guardian or other legal representative, this person's name and relationship to the Patient must be entered on the second line.

Culinary Health Fund
Available for all Plans

Authorization for Release of Protected Health Information

Fill out **completely** to prevent delay	**Submit form:** **Fax**: (702) 733-0989 **Mail**: Culinary Health Fund, 1901 South Las Vegas Blvd., Suite 107, Las Vegas, NV 89104	**For help, call:** (702) 733-9938

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

1: Participant/Member Information

Last Name	First Name	Middle Initial	Date of Birth	SS # or Participant ID #	Phone
Street		**Apt #**	**City**	**State**	**Zip**

2: Dependent Information

Last Name	First Name	Middle Initial	Date of Birth	SS # or Participant ID #	Phone
Street		**Apt #**	**City**	**State**	**Zip**

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

❑ At my request ❑ For a different purpose _____

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

❑ ANY and ALL information ❑ Explanation of Benefits ❑ Eligibility ❑ Enrollment ❑ Itemization of Lien
❑ Appeal ❑ Other_____

I want this authorization to expire (check one):

❑ Not until I revoke ❑ On this date (please specify): _____

❑ When the following event occurs _____
If I don't check a box, this authorization will expire in one year.

I, _____ , authorize the use or disclosure of my health information as described above. I have read and understand the contents of this form. I understand that Culinary Health Fund cannot control information after it is released. I understand that this request may include any reports, correspondence, test results, diagnosis, or medical procedures. I understand that I can revoke (cancel) this Authorization at any time by notifying Culinary Health 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. Signing this form does not change my ability to obtain treatment, payment, enrollment or eligibility for benefits with Culinary Health Fund. ***By signing and dating this form, I am allowing Culinary Health 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 Participant/Member**	**State**	**Zip**
For Office Use Only	**Date Received**	**Received By**	**Copy Maied On**	**Copy Given to Patient On**