HIPAA* General Authorization for Disclosure of Protected Health Information (PHI)/Electronic Protected Health Information (ePHI)

Health Insurance Portability and Accountability Act of 1996

St. Louis – Kansas City Carpenters Regional Health Plan (Plan)
1419 Hampton Avenue, St. Louis, MO 63139
Phone: (314) 644-4802 | Toll-Free: (877) 232-3863 | Fax: (314) 678-1110 | Email: benefits@carpdc.org

I, the **Participant** listed below, hereby request and authorize the Plan to disclose my **protected health information** (PHI) to the **Authorized Party** designated below. This Authorization is provided in addition to, and not restrictive of, any other consent or authorization I have given, or may give, to the Plan concerning my health information. By providing my signature below, I authorize my PHI/ePHI to be used or disclosed by the Plan as described in this authorization.

A. Participant whose PHI is authorized to be disclosed – Please PRINT:

Participant Last Name	Participant First Name	Participant Middle Name

Date of Birth	Last 4 Participant SSN	Best Contact Phone Number

B. Authorized Party* to receive Participant's PHI upon request – Please PRINT:

**Participant listed in Section A cannot be the Authorized Party in Section B*

Full Name of Person or Entity authorized to receive PHI/ePHI:	Relationship	Phone Number
Full Name of Person or Entity authorized to receive PHI/ePHI:	Relationship	Phone Number

The Plan may disclose the following PHI/ePHI to the Person/Entity listed above (choose all that apply):

☐ Entire Medical Record ☐ Mental/Behavioral Health Information, excludes Psychotherapy Notes

☐ Genetic Information ☐ Other, please list: _____

C. This Authorization will Expire (check one):

☐ One year from the date coverage terminates ***OR*** ☐ Indicate a different Expiration Date: _____

Important Information Concerning Participant Rights

1. The Participant is the member or dependent covered under the St. Louis – Kansas City Carpenters Regional Health Plan.
2. Participant signature on this form will not affect your treatment, payment, enrollment in health plan or eligibility for benefits.
3. Upon request, a copy of this signed Authorization will be sent to the Participant listed in Section A.
4. Participant has the right to inspect or copy the protected health information to be disclosed under this Authorization.
5. Information used or disclosed under this Authorization may be subject to re-disclosure by the person or entity authorized by the Participant and may no longer be protected by Federal Health Information Privacy Laws.
6. Participant may refuse to sign this Authorization.
7. If signed by a legally authorized Personal Representative (Power of Attorney, etc.), legal documentation must be attached.
8. Participant may revoke (cancel) this Authorization at any time in writing. A HIPAA Revocation Form is available from the Benefit Plans Office and will be provided upon request. Please note: Any revocation of this Authorization will not apply to any action that the Plan may have already taken on the Participant's behalf before receipt of the signed HIPAA Revocation Form.

D. Participant's Authorization to Release Information:

_____ _____

Participant Signature **Date**

(Signature of Parent if Participant is a minor under the age of 18) or (Legal Personal Representative, see #7 above)

_____ _____

Legal Personal Representative's Name – please print *(if applicable)* **Personal Representative's Phone Number**