OPERATING ENGINEERS TRUST FUNDS

I.U.O.E. LOCAL 12 HEALTH & WELFARE / PENSION / VACATION / DCP

100 CORSON STREET, SUITE 100 • PASADENA, CALIFORNIA 91103 • (866) 400-5200
P.O. BOX 7063, PASADENA, CALIFORNIA 91109
TTY: (626) 356-3582 WEBSITE: www.oefi.org

Authorization for Release of Medical Information

Personal Information			
Social Security Number/OE ID	Last Name	First Name	Middle Initial

Address Information		
Street Address		
City	State	ZIP Code

Home Phone Number	Mobile Phone Number	Email Address
( )	( )	

Authorization

I hereby voluntarily authorize the use or disclosure of my health information as described in this authorization.

1. Specific persons (or class of persons) or organizations authorized to provide the health information:

   _____

   _____

   _____

2. Specific persons (or class of persons) or organizations authorized to receive and use my health information:

   _____

   _____

   _____

3. Specific description of the health information I authorize to be used or disclosed: Please describe as specifically as possible the information you wish the Plan to disclose:

   _____

   _____

   _____

Continued on Reverse Side

4. Purpose of the request: I authorize my health information to be used and/or disclosed for the following specific purposes: For example, to discuss my benefits with the Fund so that I can better understand my benefits. If you do not wish to state a purpose, please state, "At the request of the individual."

_____

_____

_____

_____

5. 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 Privacy Official, 100 Corson St., Pasadena, CA 91103. I understand that the revocation is only effective after it is received and logged by the Fund Office. I understand that any use or disclosure made prior to the revocation under this authorization will not be affected by a revocation.

6. I understand that after this information is disclosed, federal law might not protect it and the recipient might disclose it again.

7. I understand that I am entitled to receive a copy of this authorization.

8. I understand that this authorization will expire on _____/_____/_____. The Plan will not condition treatment, payment, enrollment or eligibility for health plan benefits on receipt of an authorization.

Signature	
X	Date _____/_____/_____

If signed by a Personal Representative, please complete the following:			
Name of Personal Representative			
Relationship to participant or nature of authority (e.g., health care power of attorney, guardian):			
Street Address			
City	State	Zip Code	Phone Number ( )

Signature of Personal Representative	
X	Date _____/_____/_____