Authorization to Use and/or Disclose Personal Health Plan Information

Form Received By _____ Date _____

Check One:
☐ Allied Pilots Association Voluntary Supplemental Medical & Custodial Care Benefit Plan (the "Plan")
☐ Allied Pilots Association Catastrophic Major Medical Benefit Plan (the "Plan")
☐ Allied Pilots Association Employee Health Benefit Plan (the "Plan")

1. Member or Employee Name:	1a. Member or Employee Number:
1b. Member or Employee Date of Birth:	1c. Your Name:
2. Name of Person Whose Health Information is the Subject of this Authorization:	2a. Relationship to Member or Employee: Self ☐ Spouse ☐ Child ☐ Other ☐
3. Mailing Address:	4. Authority (If you are not the person in Box 2, please describe your authority to act on his or her behalf):

I hereby authorize the Plan to use and/or disclose the health information described in Sections A — E below.

Section A: Health Information to be Used and/or Disclosed.

Specify the health information to be released and/or used, including (if applicable) the time period(s) to which the information relates. Select only one (1) of the following boxes:

☐ All of my past, present or future health claims and/or medical records. ☐ All of my health information relating to Claim Number _____

☐ Other (please specify)_____

Section B: Person(s) Authorized to Use and/or Receive Information.

Specify the persons or class of persons authorized to use and/or receive the health information described in Section A:

Section C: Purposes for Which Information will be Used or Disclosed.

Specify each purpose for which the health information described in Section A may be used or disclosed. Select all of the applicable boxes below:

☐ To facilitate the resolution of a claim dispute. ☐ At my request. ☐ Other (please specify).____

Section D: Expiration of Authorization

Specify when this Authorization expires. (Provide a date or triggering event related to the use or disclosure of the information.)

☐ On the following date: _____. ☐ Upon my disenrollment from the Plan. ☐ Other (please specify)_____

Please return completed form to: HIPAA Privacy Official
Allied Pilots Association
14600 Trinity Blvd., Suite 500
Fort Worth, TX 76155
Fax 817-302-2146

Section E: Your rights:

- You can revoke this Authorization at any time by submitting a written revocation to the HPAA Privacy Official at the following address: Allied Pilots Association, 14600 Trinity Blvd., Suite 500, Fort Worth, TX 76155 or by fax to 817-302-2146.
- A revocation will not apply to information that has already been used or disclosed in reliance on the Authorization.
- Once the information is disclosed pursuant to this Authorization, it may be redisclosed by the recipient and the information will no longer be protected by HIPAA.
- The Plan may not condition Treatment, Payment, enrollment or eligibility for benefits on whether you sign the Authorization.
- This clause applies to individuals not yet enrolled in the Plan. If this Authorization was requested so the Plan can make an eligibility or enrollment determination or an underwriting or risk rating determination, then the person in Box 2 may be ineligible for enrollment or benefits if you fail to sign this form.

You will be provided with a copy of this Authorization Form, after signing, if the Plan sought the Authorization.

_____ _____

Signature **Date**