BUFFALO LABORERS' WELFARE FUND

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION (HIPAA)

I _____ give permission for the release of my medical information, including, but not limited to,
(print name)
medical claims and health plan records, as described below.

1. The Buffalo Laborers Welfare Fund (the "Fund") may disclose my medical information to *(check all boxes that apply, and fill in the person's first and last name):*
   - ☐ My husband/wife: _____ *(fill in your spouse's name)*
   - ☐ Other relative: _____ *(fill in other relative's name)*
   - ☐ Other person or company (friend, union representative, attorney, etc..:_____
     (fill in person's or company name) (if more space is needed, please use the reverse side of this form)

2. I give permission for the following medical information about me to be released over the telephone, in person, in writing or electronically to the person(s) listed in paragraph 1 above (or on the reverse side) *(check one or more box(es), and fill in details)*:
   - ☐ Any and all of my medical, dental, vision and other claims that the Fund has for all past and future dates of services
   - ☐ Specific medical, dental, vision or other claim(s) for health benefits (please fill in details below):
     Provider(s) _____
     Dates of Services _____
   - ☐ Dates of eligibility for health coverage
   - ☐ Amount of money in all my health care accounts
   - ☐ Other (please fill in)

3. The reason I am giving permission for the release of my medical information to the person(s) listed in paragraph 1 above (or on reverse side) is *(check on box and, fill in the reason below)*:
   - ☐ I'd prefer not to give a reason
   - ☐ For use for assisting me in processing my claims for medical services
   - ☐ Other reason _____(please fill in)

4. I understand that I do not need to sign this form in order for the Fund to provide health benefits to me if I am eligible for those benefits.

5. I understand that after my medical information is released to the person(s) listed in paragraph 1 above (or on reverse side), that person is not required to keep my medical information confidential.

6. Right to Revoke (Cancel) This Form: If I no longer want the person(s) listed in paragraph 1 above (or on reverse side) to know about my medical information, then I must send a written letter to the Fund at 25 Tyrol Drive, Suite 200, Cheektowaga, NY 14227, Attention: Privacy Officer, telling the Fund that I revoke (or cancel or take back) this form. I understand that the Fund cannot withdraw the medical information that the Fund has already released before I revoked (canceled) this form.

7. Expiration of this Form: This authorization form will expire on the date my eligibility for health benefits with the Fund ends, unless before that time, I notify the Fund in writing that I want the Fund to stop releasing my information to the person(s) listed in paragraph 1 above (or on the reverse side).

Signature _____ Date _____

Social Security Number _____ Date of Birth _____