Authorization for Release of Protected Health Information
SEIU Michigan Health and Welfare Fund

Participant's or Beneficiary's Name: _____

Social Security Number: _____

Date of Birth: _____

1. I authorize the SEIU Michigan Health and Welfare Fund (the "Plan"), to use or disclose: ***(check one)***

☐ **All** of my Protected Health Information maintained by the SEIU Michigan Health and Welfare Fund

☐ The following **specific** Protected Health Information *(Provide a **specific description** of the information to be disclosed)*

_____

_____

2. I authorize the following person(s) and/or organizations to receive the Protected Health Information specified above, at the request of such persons:

_____

_____

3. **I authorize the Protected Health Information to be used and/or disclosed for the following specific purpose** ***(State the purpose unless a general authorization is requested):***

_____

_____

BY SIGNING THIS FORM, I UNDERSTAND THAT:

- I do not have to sign this authorization.
- My refusal to sign this authorization will not affect my ability to obtain treatment, payment for services, enrollment or eligibility for benefits.
- **Information regarding behavioral and mental health services, substance use disorder treatments, and communicable diseases such as sexually transmitted diseases and human immunodeficiency virus (HIV infection, Acquired Immune Deficiency Syndrome or AIDS related complex) may be shared if I initial here or if I list this type of information above** _____.
- If I authorize the release of substance use disorder treatment information, the recipient cannot re-disclose this information without my permission unless permitted under federal or state law.
- Other types of information shared under this authorization may be re-disclosed by the person or organization I identified above and may no longer be protected by federal or state law.
- I may revoke this authorization at any time. To revoke this authorization, write to the SEIU Michigan Health and Welfare Fund, Attn: Privacy Officer, 30700 Telegraph Road, Suite 2400, Bingham Farms, Michigan 48025.
- I understand that the revocation will not have any effect on any actions taken before the Plan receives the revocation.
- I may request a copy of this signed authorization.
- This authorization will expire on: _____ **(list a date, event or condition).**
  If left blank, the authorization will expire when I specifically revoke it.

Printed Name _____

Signature _____ **Date** _____

If Legal Representative, Relationship to Participant/Beneficiary: _____
(i.e., Parent, Guardian, Patient Advocate, Authorized Representative, Power of Attorney. Documentation may be required.)

DON'T FORGET TO SIGN AND DATE THE FORM!
Please mail your completed form to:
SEIU Michigan Health and Welfare Fund, Attn: Privacy Officer
30700 Telegraph Road, Suite 2400 • Bingham Farms, Michigan 48025