Sound Health and Wellness Trust
Authorization for Release of Protected Health Information (PHI)

I. Information About the Use or Disclosure of PHI

Participant name: _____ SSN (last 4)/ID: _____

I, _____, hereby authorize the use and disclosure of PHI for*:
(*insert the name of the individual whose is authorizing the release of the information)*

☐ Myself, **OR**

☐ _____

(insert the name of individual on whose behalf you are making the request as a Personal Representative)*

1. Organization authorized to release and/or disclose PHI:
   ☒ Zenith American Solutions (third party administrator for the Trust Fund)
   ☐ Other, please specify: _____
2. Person or organization (or class of persons/organizations) authorized to receive the information:
   Name: _____ Daytime Telephone: (___) _____ - _____
   Address: _____
3. Check the boxes to describe the specific description of information to be used or disclosed:
   ☐ Related to eligibility for benefits for the period of _____ through _____
   ☐ Related to claims, reports and other documents for benefits for an injury or illness
   ☐ Related to payment or lack of payment of benefits for all health care providers
   ☐ Related to an appeal for benefits that has been denied
   ☐ Other: _____
4. Specific purpose of the disclosure, for example "To discuss benefits with the Trust Fund so I can better understand my benefits.":
   ☐ At my request, **OR**
   ☐ For the following reason: _____
5. This authorization will expire on (give a date or occurrence – for example, "Upon termination of enrollment in the health plan."):
   ☐ Until I revoke in writing, **OR**
   ☐ Until the following occurs: _____

II. Important Information About Your Rights

I have read and understand the following statements about my rights:

- This authorization is voluntary and I may refuse to sign it.
- I may revoke this authorization at any time prior to its expiration date by sending a written revocation notice to the Privacy Officer at 11724 NE 195th St, Ste 300, Bothell, WA, 98011 or Fax 702-216-0885. The revocation will not have any effect on any actions that the entity took before it received the revocation notice.
- I am not required to sign this authorization as a condition to receiving treatment or payment for health care; enrolling in a health plan; or establishing eligibility for benefits.
- The information that is used or disclosed pursuant to this authorization may be redisclosed by the receiving person or organization and, upon redisclosure, no longer be protected by federal privacy laws.

III. Signature of Individual or Personal Representative* making the request

_____ _____
Signature Date

Address: _____ Daytime Telephone: (___) _____ - _____

IV. *If the form is signed by a Personal Representative, complete the following information (a *personal representative is someone who has authority under applicable law to act on someone's behalf, such as a parent, guardian or durable power of attorney. Please submit a copy of such legal document, if applicable):*

Printed name of the participant's Personal Representative: _____

Relationship to the participant, including authority to act as Personal Representative: _____

Please return this form to: Privacy Officer, 11724 NE 195th St, Ste 300, Bothell, WA, 98011 or Fax 702-216-0885

Instructions for Completion of
AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION FORM "PHI"

All fields are required, except for IV "Personal Representative" (only required if signing on behalf of another individual – see instructions below).

SECTION I – Only one individual (whose information is to be released) is permitted per Authorization form.

- ***Plan Participant's Name –*** This is the employee/insurance holder.
- ***Plan Participant's Last 4 Digits of Social Security Number or Alternate ID***
- ***Name of Person Whose Information is to be Released –*** This is the 'patient' – the individual whose information is to be released. Check "MYSELF" if **you** are signing the Authorization on behalf of **yourself**, or write in the name of the person whose information is to be released (e.g. your dependent's name)*.

1. ***Organization to Release Information –*** This is the entity who is allowed to release the protected health information. *It is Pre-completed with Zenith American Solutions* or you may select "*Other*" if another entity should release information (e.g. Vision vendor, Prescription Drug vendor, etc.)
2. ***Name of The Person or Organization Authorized to Receive the Information & Their Contact Information –*** This is the organization or person who will be receiving the protected health information. If an organization's name is used, individual names can be added on the form to assist Customer Service with the ID process – names can also be provided separately.
3. ***Check The Boxes to Describe the Specific Description of Information to be Used or Disclosed***
4. ***Specific Purpose of Disclosure –*** You may check *"At my request"* or write your own purpose; for example, "To discuss benefits with the Trust Fund so I can better understand my benefits", or "My wife helps me with my EOBs and bills".
5. ***Expiration Date –*** *Must include a specific date or event.* Check "Until I revoke in writing", or write in a specific date or event, for example "Upon termination of enrollment in the health plan".

SECTION III – ***Signature of Individual or Personal Representative**** *making the request* **–** To be signed and dated by individual whose information is being released if the individual whose information is being released is of legal age in their state of residence, or the individual's personal representative* (e.g. Custodial parent or legal representative). If signed by a personal representative, complete Section IV.

***SECTION IV –** To be completed **only** if the form is signed by a personal representative

Print name and relationship, and attach legal documentation, if required (for example, a Power of Attorney, Guardianship documentation). If the participant is signing the Authorization on behalf of their dependent minor, legal documentation is not required.