SOUND HEALTH & WELLNESS TRUST
(Formerly Retail Clerks Welfare Trust)
AUTHORIZATION FOR USE
OR DISCLOSURE OF HEALTH INFORMATION

Identify below, the individual whose protected health information will be disclosed:

Name:_____ Birth Date: _____/_____/____
MM DD YR

Address: _____ Home Telephone No.: _____
_____ Work Telephone No.: _____
_____ E-mail Address: _____

Last 4 digits of the Covered Employee's Social Security Number: _____

PURPOSE OF AUTHORIZATION

This Authorization is required for the Sound Health & Wellness Trust to release your health information to someone other than yourself or for purposes outside the Trust's normal operations (treatment, payment of claims or healthcare operations). The recipients of this Authorization will rely on it to disclose your health information. Please review it carefully.

NATURE OF DISCLOSURE BEING AUTHORIZED

The information requested in Questions 1 through 7 must be provided for this Authorization to be effective.

1. **Describe Information To Be Disclosed**: Identify here what you authorize to be used or disclosed. The information should be specific such as "Information related to my knee surgery":

List information here: _____
_____
_____

2. **Describe the Purpose of the Disclosure**: List why the information is being disclosed. If you are initiating the request, you can simply list "At the request of the individual."

List purpose: _____
_____
_____

3. **Identify Who Is Authorized to Disclose the Information:** Identify here who is authorized to make the disclosure. Be specific such as the "Trust Office." Check each box which applies

- ☐ Trust Office Claims Payment
- ☐ First Choice (Network Manager)
- ☐ Prescription Drug Manager
- ☐ VSP
- ☐ All of the Above
- ☐ Other: _____

4. **Identify Who Will Receive the Information:** List here who is authorized to receive information such as "Mary Jones, my spouse" or "John Doe, my union representative."

_____

_____

_____

5. **Identify How To Provide Information:** Where and how should the information be disclosed? List address, e-mail, facsimile, etc. Please remember that the information being sent is your private health information.

_____

_____

_____

6. **Expiration Date of Authorization:** Indicate when your authorization will end. This can be a date ("December 31, 2004") or the happening of an event ("when decision is reached on my appeal"). Unless otherwise indicated this authorization will be good for one year.

Choose and complete one:

a. ☐ On _____/_____/_____
MM DD YR

b. ☐ Upon the occurrence of the following event: _____

_____

7. **Signature and Date:** This document must be signed and dated.

Signature and Date: _____

STATEMENT OF RIGHTS REGARDING THIS AUTHORIZATION

General Rights. I understand I am not required to sign this form and that a Covered Entity receiving it cannot condition treatment, payment or eligibility on my decision to sign this form. I understand, however, that the Sound Health & Wellness Trust can condition enrollment in the Plan or eligibility for benefits on receiving an authorization if the purpose is to allow the Trust to obtain information it needs to make an eligibility, enrollment or underwriting decision and psychotherapy notes are not requested.

Right to Revoke. I understand that I have the right to revoke this authorization in writing except as to uses and/or disclosures already made in reliance on it. Authorization revocation forms can be obtained by contacting the Trust Office listed in the Sound Health & Wellness Trust's Privacy Notice.

Effect of Disclosure. I understand that if the persons to whom my health information is disclosed are not subject to the HIPAA Privacy Rule (i.e. are not a health plan, health care provider or health care clearinghouse), the disclosed health information may no longer be protected by the HIPAA Privacy Rule and may be redisclosed without my authorization.

Retention and Right to Copy. I understand that a Covered Entity which receives this Authorization must retain a copy and that I am required to receive a signed copy as well.

Provisions Related to Psychotherapy Notes. I understand that an Authorization is required for any use or disclosure of psychotherapy notes except in the limited situations dealing with treatment, training or defense of legal actions as defined in 45 CFR 164.508(a)(2).

PERSONAL REPRESENTATIVE

This section only needs to be answered if this authorization is being completed by someone other than the individual who is the subject of the health information.

The Sound Health & Wellness Trust, for purposes of the Privacy Rule will treat a properly designated personal representative as the individual without the need for an authorization. This will apply when the individual is deceased, a personal representative has been designated in accordance with applicable law, or the individual is an unemancipated minor and state law does not prohibit disclosure to a parent or other guardian. The Trust reserves the right to decline to recognize an individual as a personal representative if there is a reasonable belief that the individual whose information would be disclosed has been or could be subject to abuse, neglect or endangerment by disclosure. Disclosure also will not be made if inconsistent with applicable law.

Except as limited by state law of the Privacy Rules, no authorization is needed to disclose information to a natural parent or legal guardian of an unemancipated minor.

a. Name of Personal Representative: _____

b. Basis for Being Personal Representative (e.g. parent, executed health care power of attorney, etc.) Attach a copy of any document creating your authority to act for the named individual.

_____

_____

Address: _____ Telephone No.: _____

_____ E-mail Address: _____

_____

Signature: _____ Date: _____

Mail to: Privacy Contact Person or
Name of the SHWT Customer Service Representative you have been speaking with
201 Queen Anne Ave. N. Suite 100
Seattle, WA 98109

Or Fax to: Privacy Contact Person or
Name of the SHWT Customer Service Representative you have been speaking with
206-352-9730 or 1-866-277-3927

SOUND HEALTH & WELLNESS TRUST
(FORMERLY RETAIL CLERKS WELFARE TRUST)
REQUEST FOR RESTRICTIONS ON THE USE AND/OR DISCLOSURE OF PHI

Participant Name: _____ Birth Date: ____/_____/____
MM / DD / YR

Address: _____
_____

Home Telephone Number: _____ E-mail: _____
Participant Identification Number and/or Social Security Number: _____

I, _____, am requesting that the Sound Health & Wellness Trust restrict the use and/or disclosure of my health information (information that constitutes protected health information as defined in the Privacy Rule of the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996) in the manner described below. I understand that the Plan may deny this request for any reason. I also understand that if agreed to, the Plan may not be able to honor this request if I require emergency treatment and that the Plan may remove this restriction in the future, if I am notified in advance.

Description of Restriction of the Health Information to be Used or Disclosed. The following is a description of the specific health information I wish to restrict:

_____

_____

Persons/Organizations Restricted from Use and/or Disclosure of Health Information. I request that the following person(s) and/or organization(s) not be allowed to use, receive and/or disclose the health information described above.

_____

By signing this form, I am confirming that it accurately reflects my wishes.

_____ _____/_____/_____
Signature Date

If signed by personal representative:
Name of personal representative: _____

Relationship to participant or nature of authority: _____

_____ _____/_____/_____
Signature of Personal Representative Date

SOUND HEALTH & WELLNESS TRUST
(FORMERLY RETAIL CLERKS WELFARE TRUST)

REQUEST FOR CONFIDENTIAL COMMUNICATIONS

Name of individual making request: _____
Birth Date: ___ /_____/___
MM / DD / YR
Address: _____
_____
Home Telephone Number: _____ E-mail: _____
Participant Identification Number and/or Social Security Number: _____

I, _____, am requesting that the Plan communicate with me in the alternative manner and/or location described below regarding my health information (information that constitutes protected health information as defined in the Privacy Rule of the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996). Such restriction is necessary to prevent a disclosure that could endanger me. I understand that the Plan may deny this request if it imposes an unreasonable administrative burden.

Description of the Health Information that Must be Communicated Confidentially. The following is a description of the specific health information to which this request applies:

_____

_____

Alternative Manner and/or Location. I request that the Plan only communicate with me in the following manner and/or at the location described below:

_____

_____

By signing this form, I am confirming that it accurately reflects my wishes.

_____ _____/_____/_____
Signature Date

If signed by personal representative:
Name of personal representative: _____

Relationship to participant or nature of authority: _____

_____ _____/_____/_____
Signature of Personal Representative Date

Submit Form to: **Privacy Contact Person, 201 Queen Anne Avenue N., Suite 100, Seattle, WA 98109; (206) 352-9730 or 1-866-277-3927**