Southern California
United Food & Commercial Workers Unions
and Food Employers Joint Benefit Funds Administration, LLC
6425 Katella Avenue, Cypress, CA 90630-5238
PO Box 6010, Cypress, CA 90630-0010
714-220-2297 • 562-408-2715 or 877-284-2320
scufcwfunds.com

PHI AUTHORIZATION

If you want the United Food and Commercial Workers Unions & Food Employers Benefit Fund (the "Plan") to disclose any of your Protected Health Information ("PHI") to another person or entity, including to a person you have appointed as your Authorized Representative for purposes of pursuing a claim for benefits or an appeal of a denied claim, please complete this PHI Authorization ("Authorization") and submit it to the Plan as instructed below. Please refer to the Plan's Privacy Notice for a description of PHI. For purposes of this form, "Individual" means a person who participates in the Plan as a Covered Employee or a covered spouse or dependent child of a Covered Employee, whose information will be disclosed pursuant to this Authorization.

1. Information about the Individual:

a. Individual's name:_____b. Fund ID#* :_____

c. Individual's birth date: _____

d. Is the Individual covered under the Plan as a dependent? ☐ **Yes** ☐ **No**

If "yes", please complete the following:

e. Covered Employee's name: _____

f. Covered Employee's birthdate:_____

**If you don't know the Family Unique ID#, then please provide the last four digits of the SSN of the Covered Employee*

2. Information about the Requestor (if applicable):
*Complete this section only if this form is submitted by someone other than the Individual, e.g., a Personal Representative such as a parent or other legal guardian or a person with power of attorney.***

a. Requestor's name: _____

b. Requestor's relationship to Individual:_____

c. Requestor's Family Unique ID#* (if applicable):_____

3. Information about the PHI: Describe your specific PHI (or the specific PHI of the Individual you represent) that you authorize the Plan to use or disclose:

For example, describe: (i) the health records you authorize the Plan to use or disclose by date(s) of service and/or name of health care provider(s); (ii) the eligibility information you want disclosed; and/or (iii) the information related to an appeal from a claim denial.

_____

_____

4. Purpose of the Disclosure: If this Authorization is at your request, you may initial here _____ to state that the purpose is "At the request of the individual signing below." Otherwise, describe the specific purpose of the use or disclosure:_____

_____

5. Information about the Recipient: Provide the name and contact information for each person or entity to whom the above described PHI may be disclosed. Attach additional sheets, if necessary. *Please note – once the PHI is disclosed to these persons or entities pursuant to this Authorization, we cannot prevent the re-disclosure of of the PHI by such persons or entities.*

Name of Person or Entity _____ Telephone Number _____

Street _____

City _____ State _____ Zip Code _____

6. Expiration Date or Event: This Authorization will expire _____ [insert expiration date or event relating to you personally]; otherwise, this Authorization will remain in effect for one year or until revoked by you in writing, whichever is earlier.

Read and sign the following statement:

I authorize the Plan to use and disclose my PHI (or the PHI of the Individual I represent) as described above. I understand that: 1) PHI disclosed in accordance with this Authorization may be re-disclosed by the recipients listed in this Authorization and, as a result, may no longer be protected under applicable health privacy laws or under the Plan's notice of privacy practices; 2) payment of my Plan claims and eligibility for my Plan benefits (or payment of the claims of the Individual I represent and such Individual's eligibility for his or her benefits) are not affected by my decision to complete this Authorization; and 3) this Authorization is valid until the revocation date indicated above, or until I revoke it in writing. I understand that I have the right to revoke this Authorization at any time by submitting a revocation form to the Privacy Officer at the address below, except to the extent that the Plan has already used or disclosed my PHI in reliance on this Authorization. Revocation forms are available upon request from the Privacy Officer.

Signature:* _____ **Date:** _____

***You are not permitted to make this request on behalf of another person, unless you are that person's Personal Representative under HIPAA. If you are making this request as an Individual's Personal Representative, a completed HIPAA Personal Representative Form generally must be on file with the Plan.*

This completed Authorization must be received by the Plan at: Privacy Officer, United Food and Commercial Workers Unions & Food Employers Benefit Fund, PO Box 6010, 6425 Katella Avenue, Cypress, California 90630. Fax: 714-220-2002.

If you have questions about this Authorization, contact the Plan at 714-220-2297, 562-408-2715, or 877-284-2320 ext. 380.

For internal use only:
Date received:_____ Date revoked:_____