Pipeline Industry Benefit Fund ♦ PO Box 470950 ♦ Tulsa OK 74147-0950
Phone 918 280-4800 ♦ Fax 918 280-4899

Authorization for Release of Personal Health Information

Help us communicate benefits to you and your family. Federal law requires that every adult covered person must give a written authorization before we may disclose personal health information to another person, such as a spouse or other family member about the individual's treatment or coverage. If an authorization is not on file, we can disclose information **only** to the covered person.

Please complete and return this form to us so that we know to whom we are authorized to disclose information regarding your health benefits coverage and medical treatment. Health care providers (doctor, hospital, etc.) do **not** need to be listed on this form.

__________________________________ __________________________________
EMPLOYEE/MEMBER NAME MEMBER'S IDENTIFICATION NUMBER

ATTENTION ALL PERSONS OVER 18 YEARS OLD COVERED UNDER THE PIBF PLAN. Please read both pages of this Authorization Form carefully and then complete and sign each statement below that applies. Please **print** legibly.

By signing below, I have authorized the Pipeline Industry Benefit Fund to disclose my health information as described in this Authorization. I have had an opportunity to review and I understand the contents of this entire form (pages 1 and 2) and I am confirming that it accurately reflects my wishes. I acknowledge that, this agreement shall be enforced under Federal laws as well as the laws of the State of Oklahoma. The information authorized for disclosure may include information which may be considered of a sensitive nature and I understand that if the person/organization authorized to receive and use the information is not a health plan or health care provider, the disclosed information may no longer be protected by federal privacy regulations.

☐ I am the Employee/Member and I authorize you to disclose information to my spouse, ______________________
Spouse Name
Signature ____ Date Signed _________________________

☐ I am the Spouse of the Employee/Member and I authorize you to disclose information to my wife/husband.

Signature ____ Date Signed _________________________

☐ I am a Dependent Child, age 18 or older. My name is ____and

I authorize you to disclose information to ____
Name and Relationship
Signature ____ Date Signed _________________________

☐ **Other** or additional Authorization. I am ____ and I authorize you to

Disclose information to ____
Name(s) and Relationship(s)
Signature ____ Date Signed _________________________

State of _______________

County of ______________

____ personally appeared before me and acknowledged the execution of the foregoing instrument.

Sworn to and subscribed before me this ______ day of _______________, 20____.

My Commission Expires: __________________________________
Notary Public

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Description of Information to be Disclosed by the Plan. I understand that the information that may be disclosed by the Plan will include all information created by or received by the Plan related to my medical treatment, health conditions, and eligibility for health benefits and/or payment of health benefits by the Plan.

Expiration of Authorization. This authorization will expire (1) at such time there is a consecutive 12 month lapse in eligibility for benefits under the Plan, (2) as to a person who has authorized disclosure to his/her spouse, upon the dissolution of marriage, (3) as to a dependent child who has authorized disclosure to a parent, at such time as the dependent fails to meet dependent guidelines as outlined in the SPD and no longer qualifies for dependent coverage under the Employee/Member's PIBF Plan, or (3) when the authorizing individual revokes the authorization in writing.

Right to Revoke. I understand that I have the right to revoke this authorization at any time by notifying the Pipeline Industry Benefit Fund in writing. I further understand that the revocation is effective only after it is received at the Benefit Fund Office and that any use or disclosure made prior to the revocation will not be affected by the revocation. To revoke the authorization, mail written request to:

Pipeline Industry Benefit Fund
Attention: Claims Department
PO Box 470950
Tulsa OK 74147-0950

Voluntary. I understand that I am under no obligation to sign this authorization form. I acknowledge that I am voluntarily signing this form to release my health information to the party I have designated.

Benefits Not Conditioned on Authorization Form. I understand that eligibility for benefits is not conditioned on this authorization form.

Potential for Redisclosure. I understand that after my health information is disclosed, federal law might not protect it, and the recipient could redisclose it.

Right to Copy. I understand that I am entitled to receive a copy of this authorization.

Photocopy and Facsimile. A photocopy or facsimile of this signed authorization form shall be considered as valid as an original signed copy.

Purpose of Disclosure: This form authorizes the Pipeline Industry Benefit Fund to disclose personal health information regarding the named individual(s) to the person(s) designated pursuant to each individual request.