SOUTHERN CALIFORNIA PIPE TRADES ADMINISTRATIVE CORPORATION
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AUTHORIZATION TO DISCLOSE CONFIDENTIAL INFORMATION

PART 1—INSTRUCTIONS

This form is used to authorize the Southern California Pipe Trades Administrative Corporation ("Fund Office") to disclose information held by any of the Southern California Pipe Trades trust funds.

If you want to authorize the Fund Office to disclose your or your minor child's Protected Health Information ("PHI") to someone other than you, you must complete this form and return it to the Fund Office.

PHI is information created, received, transmitted, or stored by the Fund Office which relates to your past, present, or future physical or mental health, health care, or payment for health care and either identifies you or provides a reasonable basis for identifying you. Except as permitted by law, the Fund Office may not use or disclose PHI to persons other than those you specify on this form.

This form is not needed if you are requesting your own PHI. Additional information regarding PHI can be found in your Summary Plan Description.

If this form pertains to non-PHI only, skip Parts 3, 5, and 8. If this form pertains to PHI only, skip Part 6.

PART 2—PARTICIPANT INFORMATION

Participant Name _____ Social Security Number (only last four digits required) _____

Address _____

Date of Birth _____ Phone Number _____ Email Address _____

PART 3—PATIENT INFORMATION FOR HEALTH DISCLOSURE (IF DIFFERENT FROM PART 2)

COMPLETE THIS SECTION ONLY FOR PHI DISCLOSURE

Patient Name _____ Social Security Number (only last four digits required) _____

Address _____

Date of Birth _____ Relationship to Participant _____

PART 4—AUTHORIZED PERSON

RELEASE MY PHI AND/OR OTHER FUND INFORMATION TO:

Authorized Person Name _____ Relationship to Participant or Patient _____

Email Address _____ Phone Number _____

Address _____

PART 5—DESCRIPTION OF HEALTH INFORMATION TO BE DISCLOSED

I AUTHORIZE THE FUND OFFICE TO DISCLOSE THE FOLLOWING PROTECTED HEALTH INFORMATION (PHI):

☐ ALL PHI (including mental health, genetic testing, and substance abuse information, if any)

☐ ALL PHI, EXCEPT (please specify): _____

☐ ONLY the following PHI (please specify): _____

PART 6—DESCRIPTION OF NON-HEALTH INFORMATION TO BE DISCLOSED

I AUTHORIZE THE FUND OFFICE TO DISCLOSE NON-PHI INFORMATION (INCLUDING ACCOUNT BALANCE DETAILS) FOR THE FOLLOWING FUND(S):

☐ ALL funds

☐ ONLY the following funds: ☐ Vacation & Holiday Benefit ☐ Defined Contribution Fund ☐ Retirement Fund ☐ Christmas Bonus Fund

PART 7—EFFECTIVE PERIOD

I WANT THIS AUTHORIZATION TO BE VALID:

☐ INDEFINITELY from the signature date in Part 9 below

☐ UNTIL the following date: _____

Note: You may cancel this authorization at any time, no matter which option you select above, by submitting to the Fund Office a properly completed Cancellation of Authorization Form available on www.scptac.org.

PART 8—PURPOSE OF HEALTH INFORMATION DISCLOSURE

THE PURPOSE FOR WHICH MY PHI INFORMATION MAY BE DISCLOSED IS AS FOLLOWS:

☐ ANY purpose
(including payment, eligibility, preauthorization, health care claims or appeals, coordination of benefits, premiums and co-payments, subrogation, reimbursement, and access to my HRA mobile app/online portal login credentials, including making requests for password resets)

☐ ONLY the following purpose (be specific): _____

PART 9—AUTHORIZATION

I AUTHORIZE THE FUND OFFICE TO DISCLOSE MY INFORMATION, IN WRITTEN, ELECTRONIC, OR ORAL FORM, TO THE PERSON IDENTIFIED IN PART 4.

I understand that:

- I have the right to revoke this form at any time by submitting a completed Cancellation of Authorization Form to the Fund Office.
- The person I am authorizing to receive my information may not be required to treat this information as confidential.
- If I am acting as the Personal Representative of the individual whose information is to be disclosed, I must provide proof of my authority to act for that individual.

X _____ _____

Participant or Patient Signature — Date

(Parent or Legal Guardian if the patient is a minor child, or a Personal Representative)

_____

Print Name