BAY AREA DELIVERY DRIVERS SECURITY FUND
HIPAA AUTHORIZATION FOR RELEASE OF INFORMATION

Participant Name: _____ Birth Date: _____/_____/_____
Address: _____
Home Telephone Number: _____ Work Telephone Number: _____
E-Mail: _____

By signing this authorization form, I hereby authorize the Bay Area Delivery Drivers Security Fund ("Plan") to use and/or disclose my individually identifiable health information in the manner described below. I understand that I am under no obligation to sign this form.

1. Description of the Health Information I Authorize to be Used or Disclosed (example: information relating to my claim or eligibility for benefits):

_____

_____

I understand that the Plan requires my more specific authorization to disclose certain health information about me. By writing my initials in the space below, I hereby authorize the Plan to disclose the following information about me: Chemical dependency_____ HIV/AIDS_____ Genetic Information_____ Mental Health Information_____

2. Purpose of the Requested Use or Disclosure (example: to assist in the resolution of my claim or eligibility status): _____

_____

3. Person(s)/Organization(s) Authorized to Receive and/or Use My Health Information—include name and phone number if applicable—(example: company human resources official at _____ union representatives, spouse) _____

_____

I understand that the health information disclosed pursuant to this authorization may be re-disclosed by the receiving party and may thereafter no longer be protected by the federal privacy standards.

4. Your Rights with Respect to This Authorization:

4.1 Right to Revoke. I understand that I have the right to revoke this authorization in writing at any time. To obtain a copy of a revocation form I will contact the Privacy Official at 1-800-654-1824. I understand that any revocation will not be effective as to uses and/or disclosures of my health information made by the Plan prior to receiving such revocation in reliance upon this authorization.

4.2 No Effect on Treatment, Enrollment or Eligibility. I understand that the Plan may not condition payment from and enrollment in the Plan or eligibility for Plan benefits on my completion of this authorization.

5. Expiration of Authorization. This authorization will expire on MM_____/ DD_____/ Y_____ or, if you do not fill in a date, 24 months after the date this authorization is signed.

I hereby acknowledge that I have reviewed and understand the contents of this authorization. By signing this form, I am confirming that it accurately reflects my wishes.

_____ _____/_____/_____
Participant Signature (or Personal Representative) Date

If signed by a personal representative, complete the following: name, address and phone number of personal representative:

_____

_____

Relationship to participant or nature of authority (e.g., health care power of attorney, guardian, other statutory authorization):

_____