Amalgamated Employee Benefits Administrators
Delivering High Quality, Customized TPA Services

Amalgamated Employee Benefits Administrators Disability Benefits Claim Department
P.O. Box 5453, White Plains, NY 10602-5453
submitclaimforms@amalgamatedbenefits.com
Toll-Free: 1-866-975-4091 / Fax: 1-914-367-4114

International Masonry Training and Education Foundation
Maternity Disability Benefit
AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

Patient Name (First) (Middle) (Last)	Social Security #
Address	Date of Birth (mm/dd/yy)

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form. In accordance with the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 42 U.S.C. 290dd-2 and its implementing regulations at 42 C.F.R. Part 2, I understand the following:

I hereby give permission and authorize any health care provider including, but not limited to, any health care professional, hospital, clinic, laboratory, pharmacy or other medically related facility or service; health plan; rehabilitation professional; vocational evaluator; and employer that has information about my health, employment history, or other insurance claims and benefits to disclose any and all of this information to persons who administer and evaluate claims for Amalgamated Employee Benefits Administrators(AEBA), including Amalgamated Medical Care Management (AMCM), an affiliate of Amalgamated Employee Benefits Administrators.

Genetic Information: NOTE TO ALL HEALTH CARE PROVIDERS: The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information, as defined by GINA, when responding to this request for medical information.

This authorization may include disclosure of information relating to: Alcohol and Drug abuse, Mental Health Treatment, except psychotherapy notes, and Confidential HIV Related Information, only if I place my initials on the appropriate item below. In the event the health information described below includes any of these types of information, and I initial the line on the box in the item below, I specifically authorize release of such information to Amalgamated Employee Benefits Administrators (AEBA), including Amalgamated Medical Care Management (AMCM), an affiliate of Amalgamated Employee Benefits Administrators.

IMPORTANT– Please complete the check boxes below even if the categories should not necessarily apply to the patient's medical records.

☐ Do ☐ **Do Not** want information about Mental Health released _____ (initial)
☐ Do ☐ **Do Not** want information about HIV Tests & Related Information released _____ (initial)
☐ Do ☐ **Do Not** want information about Alcohol and/or Substance Abuse released _____ (initial)

If I am authorizing the release of HIV-related, alcohol, or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV related information without authorization.

I understand that any information AEBA or AMCM obtains pursuant to this authorization will be used for evaluating and administering my claim(s) for disability benefits. I further understand that authorized recipients to my medical information may, in certain instances, have the right to redisclose my medical documentation without the need to obtain additional written consent from me. I understand that such redisclosures may no longer be protected by federal or state law.

I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure. However, if I do not authorize release of my medical information, this may result in Amalgamated Employee Benefits Administrators not being able to process my claim.

I have the right to revoke this Authorization at any time by providing written notice of revocation to Amalgamated Employee Benefits Administrators. I am aware that my revocation will not be effective until received by Amalgamated Employee Benefits Administrators and will not be effective regarding the uses and/ or disclosures of my "Information" that has been made prior to receipt of my revocation. This authorization is valid for one year from the date below or the duration of my claim, whichever is shorter. A photographic or electronic copy of this authorization is as valid as the original. I understand I am entitled to receive a copy of this authorization.

This authorization does not authorize my medical provider to discuss my health information or medical case with anyone other than AEBA or AMCM.

_____ _____

Patient's Signature or representative authorized bylaw **Date**

If other than patient: I signed on behalf of the patient as _____(relationship).

If Power of Attorney Designee, Guardian, Conservator, please attach a copy of document granting authority.