Amalgamated Life
Group • Stop Loss • Voluntary

Amalgamated Life Insurance Company
Claim Department
P.O. Box 5453, White Plains, NY 10602-5453
Toll-Free: 1-866-975-4089 / Fax: 1-914-367-4114

AUTHORIZATION TO RELEASE INFORMATION
Please See The Reverse Side For Instructions

SECTION #1 – Participant Member Information

First Name	Last Name	Identification Number or Social Security Number	Control Number OFFICE USE ONLY

SECTION #2 – Patient or Legal Representative

I, _____ , hereby give permission to Amalgamated Fund Administrators, or any of its other affiliates or agents and their staff performing services in connection with my claims for health plan benefits, to disclose my protected health information (PHI) to the following class of persons:

SECTION #3 – Authorized Person(s) To Receive My Information (Please Check All That Apply)

☐ Spouse _____ **(Name)**

☐ Other _____ **(Name and Relationship)**

☐ Adult Child (1) _____ **(Name)**

☐ Adult Child (2) _____ **(Name)**

☐ Union Representative _____ **(Name)**

☐ Employer _____ **(Name)**

NOTE: Please inform your representative(s) that they will be asked to verify their identity when contacting our office on your behalf.

SECTION #4 – Information To Be Disclosed (Please Check All That Apply)

I authorize the Plan to disclose protected health information (PHI) to the person(s) identified in Section 3 of this form in connection with (mark ALL that apply):

☐ **Hospital/Medical Claims** ☐ **Prescription Claims** ☐ **Vision & Dental Claims** ☐ **Mental Health Claims**
☐ **Specific claim for health benefits (describe the event and/or claims involved and date of service):**

SECTION #5 – Purpose of Disclosure

I understand that this form permits the individual(s) authorized in SECTION #3 to obtain ONLY claim payment information unless I choose to check the box below which will authorize them to obtain all my information.
☐ **At the request of the individual**
OTHER _____

SECTION #6 – Duration of Authorization

This authorization shall remain in effect for **two years** unless one of the following events occurs earlier: 1) I lose my coverage; 2) I write a letter requesting the ending of the authorization; or (3) the date I select comes first
_____/_____/_____ (insert ending date/optional)

SECTION #7 – Statement of Understanding

I understand that: **1)** I may revoke this authorization in writing at any time by submitting a cancellation of this authorization to the Plan; **2)** If I complete more than one of these forms each will be honored until I revoke one or more of these forms; **3)** A revocation will not be effective retroactively for information exchanges that have already occurred; **4)** Disclosure of my protected health information (PHI) could occur by the person(s) who have been authorized by me to receive this information; **5)** Any further disclosure by this authorized representative is not covered by HIPAA guidelines; **5)** I have the right to refuse to sign this authorization form; **7)** Treatment, payment, enrollment and eligibility for benefits may not be conditioned on obtaining an authorization.

_____ _____
Signature of Patient or Legal Representative **Date**

_____ _____
Signature of Parent, Guardian, Conservator or Other Legal Representative **Date**

NOTICE TO RECIPIENT OF INFORMATION

The designation of an "authorized representative" is in keeping with the Health Insurance Portability & Accountability Act (HIPAA) of 1996 governing privacy and security standards associated with the handling and/or transmission of your protected health information (PHI). This process is designed to assure that the persons acting on your behalf have access to your records for the purpose permitted by you.

Amalgamated Life
Group • Stop Loss • Voluntary

ABOUT THIS FORM

Under the Health Insurance Portability & Accountability Act (HIPAA) of 1996, an authorization is required to permit Amalgamated Life Insurance and any of its affiliates to release protected health information (PHI) about you to another family member or 3rd party who contacts us on your behalf. For example, if your spouse calls regarding your claims, you must complete a form authorizing the release of information to him/her.

PHI is information that is created, received, transmitted or stored by the Plan, 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 Plan may not use or disclose PHI to persons other than those specified in your signed authorization form. If you want different people to have access to different information, you must complete separate forms.

Each covered adult (including children OVER the age of 18) must complete a form in order for PHI to be released to someone other than the party incurring the claim. Information on minor children can generally be released to a parent without an authorization unless the minor obtained treatment without need for prior consent.

INSTRUCTIONS

Please complete the form as follows:

SECTION #1 Fill in the participant/member's name and identification number/social security number.

SECTION #2 Fill in your name as the "patient" or "legal representative."

SECTION #3 Check ALL person(s) and class of persons to whom you will permit disclosure of your PHI. **NOTE: A "UNION REPRESENTATIVE" may include a Business Agent, Insurance Secretary, Shop Steward or any Union Official. An "EMPLOYER" is defined as a Human Resource Representative and/or the Principal Business Owner.**

SECTION #4 Please make your selection regarding the type of disclosure permitted.

SECTION #5 Please specify the purpose(s) of the use or disclosure. This authorization form allows your authorized person identified in Section #3 to obtain ***ONLY*** claims payment information unless you check the box "at the request of the individual" and hereby grant access to all your information. You may also add any other purpose by completing the line marked "Other."

SECTION #6 Please specify a date or event for the expiration of the authorization where appropriate.

SECTION #7 Please read this section carefully. Be sure to sign and date the form. Once completed, make a copy for your records. Please mail this form to the address indicated on the front of form. Please use the telephone number on your identification card to contact us with any questions regarding this form.

CHANGES OR MODIFICATIONS

You may change an authorization at any time by filling out a new form and mailing it to the address indicated below. If you do not make changes, this authorization will stay in as specified in Section #6.

CONTACT INFORMATION

Fill out the following information so that we may contact you if we have any questions regarding this form:

Last Name: _____ First Name: _____

Address: _____ Apartment #: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email: _____