

**BRICKLAYERS INSURANCE AND WELFARE FUND  
AUTHORIZATION TO RELEASE INFORMATION AND/OR  
DESIGNATION OF A REPRESENTATIVE**

Member Name: \_\_\_\_\_

Member Social Security Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

I HEREBY AUTHORIZE THE FOLLOWING PERSON/ENTITY TO RECEIVE MY/THE ABOVE NAMED MEMBERS' HEALTH INFORMATION AND/OR DESIGNATE A REPRESENTATIVE TO ACT ON MY/THE ABOVE NAMED MEMBER'S BEHALF:

\_\_\_\_\_  
Print: Name of Authorized Person/Entity and/or Designated Representative

\_\_\_\_\_  
Print: Address of Authorized Person/Entity and/or Designated Representative

\_\_\_\_\_  
Print: Telephone Number of Authorized Person/Entity and/or Designated Representative

- I AUTHORIZE \_\_\_\_\_ to: (CHECK ALL ACTIONS THAT APPLY)
- ( ) Release claims, payment, premium eligibility, medical, management, and benefit information to the above named Authorized Person/Entity and/or Designated Representative (strike out any items that do not apply).
- ( ) Allow my Designated Representative to update my enrollment information (e.g.: address, telephone).
- ( ) Allow my Designated Representative to file a complaint, grievance or appeal on my behalf (strike out any items that do not apply).
- ( ) Other (specify) \_\_\_\_\_

- PURPOSE OF THIS AUTHORIZATION (CHECK ONE)
- ( ) At the request of the member
- ( ) following purpose: \_\_\_\_\_

- THIS AUTHORIZATION IS VALID FOR THE DURATION OF MY COVERAGE WITH BRICKLAYERS INSURANCE & WELFARE FUND UNLESS A DIFFERENT EXPIRATION DATE IS INDICATED.  
A DIFFERENT EXPIRATION DATE IS INDICATED HERE \_\_\_\_\_ (specify month, day & year)

I understand that this authorization to release information and/or designation of a representative allow only the actions specified above and does not include the ability to make decisions concerning my healthcare. I understand that I may revoke this authorization to release information and/or designation of a representative at any time, except to the extent that action has been taken in reliance upon it, by submitting a request in writing to bricklayers. I understand that the person/entity I have named to receive information may not be subject to privacy laws. They may be able to release the information and privacy laws may no longer protect the information.

I do hereby affirm that I am the above-mentioned member or the person with legal authority to act on behalf of the above-mentioned member (please note that any legally authorized person other than a parent must attach appropriate legal documentation to the form, e.g. power of attorney, legal guardianship or court order).

\_\_\_\_\_  
Signature of Member/Parent/Legally Authorized Person

\_\_\_\_\_  
Print Name of Member/Parent/Legally Authorized Person

\_\_\_\_\_  
Date