MOTION PICTURE INDUSTRY
PENSION & HEALTH PLANS™

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION
(OPTIONAL)

This form authorizes the MPI Health Plan to disclose your health information to the person or persons you designate. Health information is information that constitutes protected health information as defined in the Health Insurance Portability and Accountability Act of 1996.

Print Name: _____ _____ _____
☐ *Participant* ☐ *Spouse* ☐ *Dependent (age 18 or older)* *Date of Birth* *Participant's ID or last 4 digits of SSN*

Address: _____
Street, City, State, ZIP Code

_____
Daytime Phone *Home Phone* *E-Mail Address*

1. Describe the health information the Plan may disclose. Check all that apply.

☐ Specific health claim(s) on file (please list): _____

☐ Total in the Eligibility Bank of Hours

☐ Other _____
(Please describe the information you authorize the Plan to disclose)

☐ Any and all information being maintained by the MPI Health Plan

2. To whom may we disclose your health information?

I authorize the following person and/or organization to receive my health information:

_____
(For example: your spouse, attorney, Union, etc.) (Please provide full names)

Understand that if the person or organization you authorize to receive your information is not a health care provider, health plan or health care clearinghouse, the information may no longer be protected by the federal privacy standards because the person or organization you authorize may disclose your health information to others without first obtaining your permission.

3. Why would you like us to disclose your health information? Check one.

☐ Specific Reason (please state) _____

_____

☐ No specific reason—at my request

4. When would you like this Authorization to expire? Check one.

☐ On _____ (mm/dd/yyyy)

☐ Until I send a revocation in writing to the MPI Health Plan.

☐ When the following happens:

_____
(At the conclusion of a trial (attorney), upon divorce from spouse, etc.)

5. Your Rights regarding this Authorization

5.1. Right to Revoke

You may revoke this authorization at any time by sending your revocation to the Plan Office in writing. (Form available online: www.mpiphp.org.) Your revocation will not stop disclosures already made.

5.2. Right to Receive a Copy of This Authorization

Let us know if you'd like us to send you a copy of your completed, signed Authorization form.

6. Confirmation/Signature

You are under no obligation to sign this form. Refusal to sign will not affect your ability to obtain treatment or payment or your eligibility for benefits. By signing this form, you are authorizing the MPI Health Plan to disclose your health information as described on page 1.

I, _____ _____ have had an opportunity to review
Print Name — Participant's ID or last 4 digits of SSN

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

_____ _____
Signature of Participant, Spouse or Dependent (age 18 or older) — Date

7. Complete this section only if you cannot sign for yourself and are using a personal representative to take care of your business.

_____ _____
Print Name of Personal Representative — Relationship to Participant

Address: _____
Street, City, State, ZIP Code

_____
Daytime Phone — Home Phone — E-Mail Address

_____ _____
Signature of Personal Representative — Date

SEND US A COPY OF YOUR POWER OF ATTORNEY, IF YOU ARE USING A PERSONAL REPRESENTATIVE.

RETURN FULLY COMPLETED FORM TO:

The MPI Health Plan
Attn: Claims Review Unit
P.O. Box 1999
Studio City, CA 91614-0999