Carpenters Health and Welfare Trust Fund for California
Authorization Form For Release of Medical/Health Information

265 Hegenberger Rd, Suite 100, Oakland, CA 94621
PO Box 2280, Oakland, CA 94614
Tel. (510) 633-0333 * (888) 547-2054 * Fax (510) 633-0215

Name: _____ SSN, CFAO ID#, or UBC#: _____

I, _____ , hereby authorize the use or disclosure of my health information as described in this authorization.

1. Specific person/organization (*or class of persons*) authorized to **provide** the information (e.g. Carpenters Health and Welfare Trust Fund for California):

   _____

2. Specific person/organization (*or class of persons*) authorized to **receive** and use the information: <*insert name, title/relation, address fax, phone and email if possible*>

   _____

3. Specific **description of the information to be used or disclosed**. (Include dates as appropriate):

   _____

   _____

   _____

4. **Purpose of the request**: (Check one)

   ☐ At the request of the individual signing this form.

   ☐ Other: _____

5. **Right to Revoke:** I understand that this authorization is voluntary and that I have the right to revoke this authorization at any time by notifying the Privacy Officer (in writing) at 265 Hegenberger Road, Suite 100, Oakland, CA 94621. I understand that such a revocation is only effective after it is received and logged by the Privacy Officer. I understand that any use or disclosure made prior to the revocation of this authorization will not be affected by a revocation.
6. I understand that after this information is disclosed, federal law might not protect it and the recipient might disclose it again.
7. I understand that I am entitled to receive a copy of this authorization and the information described on this form if I ask for it.
8. I understand that this authorization will expire:

   ☐ One year from the date of this authorization.

   ☐ On the following date: _____, 20_____.

9. The Plan may condition enrollment in the plan or eligibility for benefits on receipt of authorization prior to enrollment, if the authorization is sought for underwriting or risk rating determinations and does not relate to psychotherapy notes.

_____ _____

Signature of Individual **Date**

or

_____ _____

Signature of Personal Representative **Date**

If a Personal Representative executes this form, that Representative warrants that he or she has authority to sign the authorization form on the basis of:

☐ a signed Personal Representative Form;

☐ Other _____

CARPENTER FUNDS ADMINISTRATIVE OFFICE
OF NORTHERN CALIFORNIA
265 Hegenberger Road, Suite 100, Oakland CA 94621
P.O. Box 2280, Oakland, CA 94614
Tel. (510) 633-0333 ✧ (888) 547-2054 ✧ Fax (510) 633-0215
www.carpenterfunds.com

Consent for Release of Information

If you wish to authorize the Trust Fund Office to release information about your accrued benefits to someone other than you, please complete the section below:

I, _____, authorize the Trust Fund Office to release information to the person(s) listed below regarding my benefits accrued under the following Funds* (check all that apply):

- ☐ Carpenters Pension Trust Fund for Northern California
- ☐ Carpenters Annuity Trust Fund for Northern California
- ☐ Carpenters Vacation & Holiday Trust Fund for Northern California
- ☐ Northern California Carpenters 401(k) Plan

To release information or records about my accrued benefit(s) to:

Name: _____ Relationship to Participant: _____

Address: _____
Street City Zip Code

(To authorize additional people or entities please attach an additional sheet or request additional forms from the Trust Fund Office.)

I would like this authorization to expire _____. (Optional)

Participant signature: _____ Date: _____

Participant's CFAO ID#, UBC# or Social Security Number: _____

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* Please note that the Carpenters Health and Welfare Trust Fund for California has specific requirements regarding authorizations for the release of Protected Health Information. If you would like to authorize someone to have access to your benefit information under the Health and Welfare Fund please contact the Trust Fund Office for the appropriate forms or download them from our website at http://www.carpenterfunds.com/par_downloads.html#hw.

CARPENTER FUNDS ADMINISTRATIVE OFFICE
OF NORTHERN CALIFORNIA, INC.
265 Hegenberger Road, Suite 100 ✧ P.O. Box 2280
Oakland, California 94621-0180
Tel. (510) 633-0333 ✧ (888) 547-2054 ✧ Fax (510) 633-0215

GENERAL STATEMENT OF NONDISCRIMINATION: (DISCRIMINATION IS AGAINST THE LAW)

The Carpenters Health and Welfare Trust Fund for California ("Fund" or "Plan") complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. The Plan:

a) Provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

b) Provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, contact Pauline Hann, Civil Rights Coordinator.

If you believe that the Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Pauline Hann, Civil Rights Coordinator
Carpenter Funds Administrative Office of Northern California, Inc.
265 Hegenberger Rd., Suite 100
Oakland, CA 94621
Telephone number: (888) 547-2054, Fax: (510) 633-0215
Email: benefitservices@carpenterfunds.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Pauline Hann, Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW., Room 509F, HHH Building
Washington, DC 20201
1-800-868-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

ATTENTION: FREE LANGUAGE ASSISTANCE This chart displays, in various languages, the phone number to call for free language assistance services for individuals with limited English proficiency.	
Language	**Message About Language Assistance**
Spanish	ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1 (888) 547-2054. (TTY: 888-547-2054).
Chinese	注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-888-547-2054（TTY：1-888-547-2054).
French	ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-888-547-2054 (ATS : 1-888-547-2054).
Italian	ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-888-547-2054 (TTY: 1-888-547-2054).
German	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-888-547-2054 (TTY: 1-888-547-2054).
Hmong	LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-888-547-2054 (TTY: 1-888-547-2054).
Vietnamese	CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-888-547-2054 (TTY: 1-888-547-2054).
Persian	**توجه**: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-888-547-2054 (TTY: 1-888-547-2054) تماس بگیرید.
Hindi	ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-888-547-2054 (TTY: 1-888-547-2054) पर कॉल करें।
Tagalog	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-888-547-2054 (TTY: 1-888-547-2054).
Navajo	D77 baa ak0 n7n7zin: D77 saad bee y1n7[ti'go **Diné Bizaad**, saad bee 1k1'1n7da'1wo'd66', t'11 jiik'eh, 47 n1 h0l=, koj8' h0d77lnih 1-888-547-2054 (TTY: 1-888-547-2054.)
Arabic	ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-888-547-2054 (رقم هاتف الصم والبكم: 1-888-547-2054).
Korean	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-547-2054 (TTY: 1-888-547-2054) 번으로 전화해 주십시오.
Thai	เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-888-547-2054 (TTY: 1-888-547-2054).
Laotian	ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-888-547-2054 (TTY: 1-888-547-2054).