



INTERNATIONAL UNION OF OPERATING ENGINEERS

**LOCAL 4**

**Health and Welfare Fund**

## Authorization to disclose my claims information to my parents

In order for the Health & Welfare Plan to answer questions about your Health & Welfare claims with anyone other than you, we must have your permission to do so. This authorization only applies to information that the Health & Welfare Plan has on file as pertains to the processing of your claims.

**Dependent Over Age of Majority** I, \_\_\_\_\_, under parent  
(over age 18) (Print Covered Dependent Name)

UEF Number \_\_\_\_\_ authorize IUOE Local 4 Health & Welfare Plan to disclose protected health information for me as it relates to the processing of claims to the individual named below:

Name of person(s) authorized: \_\_\_\_\_ Relationship to me: Mother \_\_\_ Father \_\_\_ Other \_\_\_  
(Print Name) (Please define)

\_\_\_\_\_ Relationship to me: Mother \_\_\_ Father \_\_\_ Other \_\_\_  
(Print Name) (Please define)

I understand that this authorization may be revoked in writing to the IUOE Local 4 Health and Welfare Fund at any time, although revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. This authorization expires three years from the date signed.

Date \_\_\_\_\_ My Signature \_\_\_\_\_  
(Dependent Over age of Majority)

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