LOCAL NO. 9, IBEW AND OUTSIDE CONTRACTORS HEALTH AND WELFARE FUND ("PLAN")
One Westbrook Corporate Center, Ste. 430 Phone 708 449 9004
Westchester, IL 60154-5701 Fax 708 449 7268

PARTICIPANT DISCLOSURE AUTHORIZATION

Name (First, Middle, Last)	
Address (Street/PO Box, City, State, Zip)	
Home Telephone	Work Telephone
Mobile/Cellular	E-mail
Social Security Number	Date of Birth

I authorize the use and/or disclosure of my Protected Health Information ("PHI") as described below

1. I authorize the Plan and the Plan staff at the address above to make the authorized use and/or disclosure of my PHI. This Authorization also includes any Covered Entities that are under contractual agreement with the Plan.

2. I authorize the following persons (or class of persons) to receive my PHI:

4. I understand that, if my PHI is disclosed to someone who is not required to comply with the federal privacy protection regulations, then such information may be re-disclosed and would no longer be protected. I understand that I have a right to revoke this Authorization at any time other than specified in item 5 below. My revocation must be in writing on the Revocation of Participant Disclosure Authorization located on the lower portion of this form

5. This Authorization expires upon (give date or an event that triggers expiration):

Signature	Date

THE REVOCATION BELOW IS TO BE COMPLETED ONLY IF/WHEN YOU WISH TO TERMINATE THE ABOVE AUTHORIZATION

You may sign and submit your copy of the Authorization or contact the Plan office to obtain a new copy of the original.

REVOCATION OF PARTICIPANT DISCLOSURE AUTHORIZATION

I hereby revoke the above Participant Disclosure Authorization. I understand that this Revocation becomes effective on the date it is received by the Plan at the address shown above and not on the date of signing, if earlier.

Signature	Date