Heartland
HEALTH & WELLNESS FUND
7250 Poe Ave. • Ste. 300 • Dayton, OH 45414

Phone: 937.665.1900
Fax: 937.665.0900
heartlandwellnessfund.com

AUTHORIZATION FORM TO DISCLOSE PROTECTED HEALTH INFORMATION TO FAMILY MEMBERS

Federal privacy law limits the ability of the Heartland Health & Wellness Fund (the "Plan") to disclose your health information to others, including to your family members. The privacy law requires that every adult covered person must give a written authorization before we may disclose your health or medical information to another person, including to family members such as a spouse. If an authorization is not on file, the Plan can disclose such information only to the covered adult person to whom the information relates.

If you would like to authorize the Plan to disclose your health and medical information to your family members, then please complete and return this form to the Plan. This will authorize the Plan to disclose information regarding your medical treatment and health benefits coverage to your family members. To obtain additional copies of this form, contact the Plan.

Employee-Participant Information

Full Name (Employee-Participant)	Social Security Number	Daytime Phone Number
Street Address	City	State Zip

ATTENTION ALL PERSONS 18 YEARS OR OLDER COVERED UNDER THE PLAN. If you would like the Plan to be able to disclose your health and medical information to your family members, please read this Authorization Form carefully and then check all below that apply and sign after each statement you check:

☐ I am the Employee-Participant and I authorize you to disclose to my spouse _____
spouse name

Signature _____ Date Signed _____

☐ I am the Spouse of the Employee-Participant and I authorize you to disclose to my wife/husband.

Signature _____ Date Signed _____

☐ My name is _____ and I authorize you to disclose to

_____
Name(s) and relationship

Signature _____ Date Signed _____

☐ I am a Dependent Child age 18 or older. My name is _____

and I authorize you to disclose to _____
Name(s) and relationship

Signature _____ Date Signed _____

By signing above, I have authorized the Plan to disclose my health information as described in this authorization. I have had an opportunity to review and understand the contents of this form and I am confirming that it accurately reflects my wishes.