

AUTHORIZATION FORM TO RELEASE PROTECTED HEALTH INFORMATION (PHI)

In accordance with the Health Insurance Portability and Accountability Act (HIPAA),
I, _____ authorize the following

(First Name Last Name)

person(s)/organization(s) to obtain certain PHI from the National Benefit Center (NBC) on my behalf.

Name and address of person or organization to receive PHI:

All Local 2195 Benefit Representatives & All Alternate Benefit
Representatives

Please check the appropriate box regarding the information that you authorize to be released.

Any enrollment, eligibility or billing information maintained by the NBC.

The following information (Checking this box will authorize the named person/organization to receive only the information listed below):

Authorization Expiration Date: _____ (an expiration date response
(month/date/year) of none is acceptable)

or

Expiration Event: _____

By signing below, I acknowledge my understanding that:

- The authorization is voluntary.
- I may revoke the authorization at any time by writing to the NBC at the appropriate address below. If I do not revoke the authorization, it will be valid until such time as I am no longer a participant in the Delphi Health Care Program. My revocation will not apply to any action taken before the NBC receives it.
- PHI disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by the privacy rules of the U.S. Department of Health and Human Services.
- My refusal to sign this Authorization would not affect my eligibility for benefits or my enrollment in or coverage under the Delphi Health Care Program.

Signature: _____ Date: _____

Social Security Number: _____

National Benefit Center
P.O. Box 14673
Lexington, KY 40512-4673

Due to the recent passing of the Health Insurance Portability and Accountability Act (HIPAA), every person on site will need to complete this form and send a

copy to the National Benefit Center to authorize UAW Local 2195 Benefit Representatives to act on your behalf concerning benefits. An additional form for Blue Cross must also be completed.