

Health Reimbursement Account (HRA) HIPAA Authorization Form

I, _____, give permission to the Insurance and Pension Fund Office of Roofers Local 241 to disclose the following protected health information with respect to my HRA and WRA under the Roofer's Union Local 241 Health and Welfare Benefit Plan to:

Name of Authorized Party Relationship

Information to be Disclosed:

Reimbursement Information (including vendor/provider information)

Claim Information (including vendor/provider information, claim denials, substantiation)

Address Information

Dependent Information

Account Balance Information

Other: _____

This authorization does not expire. *

Signature of Participant Date

Printed Name of Participant

* I understand I may revoke this authorization in writing at any time by sending written notification to Insurance & Pension Fund Office Local 241, 890 Third Street, Albany NY 12206