Trucking Employees of North Jersey Welfare Fund
Reciprocal Authorization for Disclosure of Protected Health Information

I,____________________, as a participant in the Trucking Employees of North Jersey Welfare Fund, and I, _____________________, as the spouse[1] of this participant, authorize the disclosure of our protected health information[2] to one another as described herein. We understand that this reciprocal authorization is voluntary and made to confirm our directions. We understand that, if the person(s) or organization(s) that we authorize to receive our protected health information are not subject to federal and state health information privacy laws[3], subsequent disclosure by such person(s) or organization(s) may not be protected by those laws.

1. We AUTHORIZE and DIRECT the following organization to disclose our protected health information (as specified below):

Organization: **Trucking Employees of North Jersey Welfare Fund**

Address: **707 Summit Avenue, Union City, New Jersey, 07087**

2. We each authorize one another to receive the requested protected health information, as disclosed by the Trucking Employees of North Jersey Welfare Fund.

Participant Name:

Address:

Spouse Name:

Address:

3. (a) Specific description of the protected health information that we authorize for disclosure (authorization to disclose psychotherapy notes must be separate):

Any and all information maintained by the Fund office in connection with treatment and/or services provided to participant and/or spouse covered by the Welfare Fund.

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[1] As the term is used in this Authorization, "spouse" includes a husband or wife, partner in a Civil Union (as term was formerly used in N.J.S.A. 37:1-29) as well members of a same sex marriage.

[2] Protected health information ("PHI") is health information that is created or received by a health care provider, health plan, or health care clearinghouse which relates to: 1) the past, present, or future physical or mental health of an individual; 2) the provision of health care to an individual; or 3) the past, present, or future payment for the provision of health care to an individual. To be protected, the information must be such that it identifies the individual or provides a reasonable basis to believe that the information can identify the individual. 45 C.F.R. 164.508.

[3] These laws apply to health plans, health care providers,, and health care clearinghouses.

(b) As evidenced by our initials hereto: ____________________ we hereby specifically authorize and direct that this **Authorization for Disclosure of Protected Health Information** is to include mental health records, psychotherapy records, substance abuse records.

4. Specific description of the purpose for each use or disclosure (or write "At the request of these individuals" in this space):

5. The method of releasing and delivering the information is:

Regular mail _______ Overnight Delivery__________

Hand Delivery_______ Fax__________ Telephone_______

6. We understand that we may revoke this authorization in writing at any time, except to the extent that the person(s) and/or organization(s) named above have taken action in reliance on this authorization.

7. This authorization expires on:_____________________(date)
(Note: Leave blank if no expiration date is necessary).

We have had the opportunity to read and consider the contents of this authorization. We confirm that the contents are consistent with our direction.

____________________________________ ____________________________
Signed Date

Participant Name:
Address:____
Telephone: ______________________ Social Security No.:___________________

____
Relationship or Authority of Personal Representative (if applicable)

____
Witness

____________________________________ ____________________________
Signed Date

Spouse Name:
Address:____
Telephone: ______________________ Social Security No.:___________________

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Relationship or Authority of Personal Representative (if applicable)

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Witness