CARPENTERS SERVICES ADMINISTRATIVE CORPORATION

445 South Figueroa Street, Suite 1500
Los Angeles, CA 90071-3203

**Tel:** 213-386-8590 • **Toll Free:** 800-293-1370
csacbenefits.org

# HIPAA Authorization Form

Your Name: _____ Birth Date: ____ / ____ / ____
Please Print (*your signature will be required below*) MM DD YY

Your relationship with Participant: ☐ Self ☐ Spouse ☐ Dependent Child

Address: _____

Home #: (_____) _____ Work #: (_____) _____ Cell #: (_____) _____

Participant's Name: _____ Participant's SSN or UBC ID: _____

**I hereby authorize the Western States Carpenters Health and Welfare Trust (the "Trust") to use and/or disclose my Protected Health Information as follows:**

1. **Information to be Used or Disclosed**: The following Protected Health Information (PHI) may be used and/or disclosed as described below (*check those that apply*):

☐ Any health care information that you have about me
☐ Any information that relates to my eligibility for benefits provided by the Trust
☐ The dates of treatment that I received
☐ The reason(s) that I was denied benefits
☐ Other: _____
[*Please describe the information so that it is specific and meaningful*]

2. **Persons to Whom the Use of Disclosure May be Made:** The following person(s) or class of persons may receive the Protected Health Information described in Section 1 of this Authorization from the Trust and/or Carpenters Services Administrative Corporation (CSAC).

☐ Spouse's Name: _____
☐ Child(ren)'s Name(s): _____
☐ Parent's Name(s): _____
☐ Other Name: _____
[*list the name or specific designation of the person or classes of persons*]

If you only want your PHI released to someone who knows a password, provide your password here: _____

3. **Purpose of the Request:** Please state the purpose of the request below. If you do not wish to state a purpose, please enter: "At the request of the individual" _____
_____

4. **Expiration Date or Event:** This authorization will expire (*choose and complete one*):

☐ Ten years from the date this authorization is signed
☐ On ____ / ____ / ____ (*less than 10 years from the date the authorization is signed*)
MM DD YY
☐ Upon the occurrence of the following event(s) related to my health care or to the purpose(s) for which I have authorized the use and/or disclosure of my Protected Health Information: _____
_____

**I understand that:**
(1) I may revoke this Authorization in writing at any time except to the extent that the Trust has taken action in reliance on this Authorization;
(2) The Trust may not condition treatment, payment, enrollment or eligibility for benefits on my willingness to sign this Authorization; and
(3) Any information disclosed under this authorization may be subject to redisclosure by the recipient and may no longer be protected by law.

**Signature:** _____ **Date:** _____

**Submit this completed form by mail to the address above or by fax at (213) 739-9463.**

*Rev 04.2026*