**AUTHORIZATION FOR USE AND DISCLOSURE  
OF PROTECTED HEALTH INFORMATION**

**[Trinity Health Corporation Welfare Benefit Plan]**

**[Trinity Health Corporation Retiree Benefit Plan (Grandfathered)]**

This authorization is prepared pursuant to the requirements of the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191), 42 U.S.C. Section 1320d, et. seq., and regulations promulgated thereunder, as amended from time to time (collectively referred to as “HIPAA”).

**This authorization affects your rights in the privacy of your protected health information (“PHI”). Please read it carefully before signing.**

The [Trinity Health Corporation Welfare Benefit Plan] [Trinity Health Corporation Retiree Benefit Plan (Grandfathered] (the “Plan”) will not condition eligibility or enrollment in the Plan or payment or reimbursement for health care services on your providing authorization for the requested use or disclosure. YOU MAY REFUSE TO SIGN THIS AUTHORIZATION.

By signing this authorization you acknowledge and agree that [*name or specific identification of person(s) or class of person(s), including business associates, authorized to make the requested use or disclosure*] may use or disclose the following information [*identify the specific information to be used or disclosed*] for the purpose(s) of [*include a description of each intended use or disclosure. If the individual to whom the information pertains initiates the authorization, “at the request of the individual” may be used*].

By signing this authorization you agree that [*name of authorized person or entity*] may disclose your PHI to [*name or other specific identification of person(s) or entity to receive the requested use or disclosure*].

Further, by signing this authorization you acknowledge that you have been provided a copy of and have read and understand the Plan’s HIPAA Notice of Privacy Practices containing a complete description of your rights with respect to your protected health information and the permitted uses and disclosures of your protected health information under HIPAA. While the Plan has reserved the right to change the terms of its Notice of Privacy Practices, copies of the Notice of Privacy Practices, as amended, are available from the Plan at any of its offices or by sending a written request with return address to [*address of contact person*].

You have the right to revoke this authorization, in writing, at any time, except to the extent that the Plan has taken action in reliance on it or, if the authorization was obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy. A revocation is effective upon receipt by the Plan of a written request to revoke and a copy of the executed authorization form to be revoked at the following address:

[Trinity Health Corporation Welfare Benefit Plan]

[Trinity Health Corporation Retiree Benefit Plan (Grandfathered]

Attn: Privacy Official

c/o Trinity Health Corporation

Mail Stop E1C

20555 Victor Parkway

Livonia, MI 48152

Fax: (248) 347-5437

Email: [weinerjz@trinity-health.org](mailto:weinerjz@trinity-health.org)

This authorization shall expire upon the earlier occurrence of: (a) revocation of the authorization, (b) a finding by the Secretary of the U.S. Department of Health and Human Services, Office for Civil Rights, that this authorization is not in compliance with requirements of HIPAA, (c) complete satisfaction of the purpose(s) for which this authorization was originally obtained, to be determined in the reasonable discretion ofthe Plan, or (d) six years from the date this authorization is executed.

By signing this authorization you acknowledge and agree that any information used or disclosed pursuant to this authorization could be at risk for redisclosure by the recipient and no longer protected under HIPAA.

**The Plan will provide you with a copy of this signed authorization.**

Acknowledged and agreed to by:

Participant's Name Date

[OR]

On behalf of

(*Participant*)

By:

Name of Participant's Representative Date

As:

Capacity as Representative

You should return this completed form to:

[Trinity Health Corporation Welfare Benefit Plan]

[Trinity Health Corporation Retiree Benefit Plan (Grandfathered]

Attn: Privacy Official

c/o Trinity Health Corporation

Mail Stop E1C

20555 Victor Parkway

Livonia, MI 48152

Fax: (248) 347-5437

Email: [weinerjz@trinity-health.org](mailto:weinerjz@trinity-health.org)