MICHIGAN ELECTRICAL EMPLOYEES' HEALTH PLAN

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I, _____ hereby authorize the Michigan Electrical
(Printed Name)
Employees' Health Plan (the "Plan") to disclose my health information as described in this authorization.

(1) Specific person/organization (or class of person) to whom the Plan is authorized to disclose the information (for example, "my spouse" or "any health care provider who is treating me"):

_____

_____

(2) Specific description of the information to be disclosed by the Plan:

_____

_____

(3) Right to Revoke: I understand that I have the right to revoke this authorization at any time by notifying the Plan in writing at 3001 Metro Dr. Suite 500, Bloomington, MN 55425. I understand that the revocation is only effective after it is received by the Plan. I understand that any use or disclosure made prior to the revocation of this authorization will not be affected by the revocation.

(4) Potential for Redisclosure: I understand that after this information is disclosed, federal law might not protect it, and the recipient might disclose it.

(5) Right to Copy: I understand that I am entitled to receive a copy of this authorization.

(6) Expiration of Authorization. This authorization will expire April 14, 2024, unless one of the options below is checked [choose and complete one]:

☐ For as long as I am eligible for benefits from the Plan.

☐ Other: _____

(7) Voluntary: I understand that I am under no obligation to sign this form. I acknowledge I am voluntarily signing this form to release my health information to the party I have designated.

(8) Benefits Not Conditioned on Form: I understand that the Plan may not condition enrollment in the Plan or eligibility for benefits on this authorization form unless the purposed of this authorization form is to allow the Plan to obtain information it needs to make an eligibility, enrollment or under writing determination.

(9) Purpose of Authorization: I am requesting that my information be disclosed for the following purpose (individual can simply state "pursuant to individual authorization"):

_____

_____

(10) Photocopy and Facsimile: A photocopy or facsimile of this signed authorization form shall be considered as valid as an original signed copy.

I have had an opportunity to review and understand the contents of this form. By signing this form, I am confirming that it accurately reflects my wishes.

_____ _____

(Date) (Individual Signature)

_____

(MID or Social Security #)

Personal Representative Section

If a Personal Representative executes the form on behalf of the individual, the Personal Representative warrants that he or she has authority to sign this form on the basis of:

- ☐ A power of attorney for health care purposes including the right to access protected health information, notarized by a notary public (copy attached).
- ☐ A court order of appointment of the person as the conservator or guardian of the individual (copy attached).
- ☐ An individual who is the parent of an unemancipated minor child may generally act as the child's personal representative (subject to state law exceptions).
- ☐ Other: _____

Managed for the Trustees by: Wilson-McShane Corporation
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