CONSTRUCTION LEADERS

AUTHORIZATION FOR RELEASE OF INFORMATION

I, ___________________________________ and/or my spouse and my dependents, ___________
Print Employee's Name

____
Print Spouse and Dependent's Name

hereby authorize UMR, WellDyneRx and MetLife (dental provider);

1) to disclose diagnosis, treatment, and insurance information to PCL Construction Enterprises, Inc., Manager Employee Services, Benefits Supervisor, Director Human Resources and/or Broker of Record for the purpose of adjudicating and/or to resolve grievances of medical/Rx or dental claims,

2) and for Plan administrative functions such as; quality assurance, claims processing, auditing, and monitoring.

I have read and understand the following statement about my rights:

- I may revoke this authorization at anytime in writing by sending a written request to the Manager Employee Services, Human Resource Department, PCL Construction Enterprises, Denver, CO. I am aware that a revocation will not have any affect on any use or disclosure of protected health information by UMR Health Plan, WellDyneRx and MetLife (dental provider) before it received the revocation.

- I may see and copy the information described on this form if I ask for it.

- I am not required to sign this form to receive my health care benefits (enrollment, treatment or payment).

- I understand that the information that is used or disclosed pursuant to this authorization may be redisclosed by PCL Construction Enterprises. I have the right to seek assurances from PCL Construction Enterprises that they will not redisclose the information to any other party without my further authorization.

This authorization is valid from the date of my signature and shall expire one year from the date the authorization is signed.

____
Signature of Employee   Date

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Signature of Spouse   Date

Updated 2/20/2013