ATTENDING PHYSICIAN'S SUPPLEMENTARY STATEMENT

ATTENTION: No further benefits can be paid until this form is completed by the Attending Physician and returned to:

Health & Welfare Fund
Sheet Metal Workers Local Union 91
8124 – 42nd Street W.
Rock Island, Illinois 61201
(309) 787-0695, ext. 18

Part A: To be completed by Patient (Employee)

Patient's Name:_____ Date of Birth: _____

Patient's Address: _____ City: _____ State: _____ Zip:_____

Name of Employer: _____ Phone Number:_____

Employer's Address: _____ City: _____ State: _____ Zip: _____

I voluntarily authorize and request disclosure (including paper, oral, and electronic interchange) of all my medical records; also education records and other information related to my ability to perform tasks. This includes specific permission to release:

OF WHAT:

1. All records and other information regarding my treatment, hospitalization, and outpatient care for my impairment(s) including, and not limited to:
   - Psychological, psychiatric or other mental impairment(s) (excludes "psychotherapy notes" as defined in 45 CFR 164.501)
   - Drug abuse, alcoholism, or other substance abuse
   - Sickle cell anemia
   - Human immunodeficiency virus (HIV) infection (including acquired immunodeficiency syndrome (AIDS) or tests for HIV or sexually transmitted diseases
   - Gene-related impairments (including genetic test results)
2. Information about how my impairment(s) affects my ability to complete tasks and activities of daily living, and affects my ability to work.
3. Copies of educational tests or evaluations, including individualized Educational Programs, triennial assessments, psychological and speech evaluations, and any other records that can help evaluate function; also teachers' observations and evaluations.
4. Information created within 12 months after the date this authorization is signed, as well as past information.

FROM WHOM:

- All medical sources (hospitals, clinics, labs, physicians, psychologists, etc.) including mental health, correctional addiction treatment, and VA health care facilities.
- Employers

PURPOSE: For determining my eligibility for benefits

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the undersigned Physician to release any information acquired in the course of my examination or treatment.

Signed: _____ Date: _____

PART B: Attending Physician's Statement

Diagnosis and Concurrent Conditions: _____

Dates of Service: _____
(If previous form has been submitted to this carrier, you need show only dates since last report).

Dates the Patient was continuously totally disabled (unable to work):

From: _____ Thru: _____

If still disabled, please give date when the Patient should be able to return to work: _____

REMARKS: _____

_____

_____

Physician's Name: _____ Phone Number: _____

Physician's Address: _____

City: _____ State: _____ Zip: _____

Physician's Signature: _____ Date: _____

**********ATTENTION**********

IT IS THE MEMBERS RESPONSIBILITY TO INFORM THE HEALTH & WELFARE FUND OF THE RETURN TO WORK DATE, EITHER ON OR BEFORE RETURNING TO WORK. ANY BENEFITS PAID TO YOU AFTER THIS DATE WILL NEED TO BE REFUNDED.