Authorization to Release Information please print

This form is used to release your protected health information as required by federal and state privacy laws. Your authorization allows the Health Plan (your health insurance carrier or HMO) to release your protected health information to a person or organization that you choose. You can revoke this authorization at any time by submitting a request in writing to the Health Plan (contact Member Services for further instructions). Revoking this authorization will not affect any action taken prior to receipt of your written request.

Section A: Member Information: (individual whose information will be released)

Name: (First, Middle, Last, Title)	**Member ID Number**	**Date of Birth:** (Month/Day/Year)
1		

Address: (including zip code)	**Telephone Number:** (including area code)

Section B: Health Plan: (organization that will release your information)

I authorize INDEPENDENCE BLUE CROSS and MAGELLAN to release my protected health information as described below.
(Health Plan name on your ID card)

Section C: Recipient: (person or organization that will receive your information

Person's Name or Organization:	**Telephone Number:** (including area code)
LAW ENFORCEMENT HEALTH BENEFITS, INC.	(215) 763-8290
Address: (including zip code)	**Fax Number:** (including area code)
2233 SPRING GARDEN ST, PHILADELPHIA, PA 19130	(215) 763-8808

Section D: Description of Information to be released: (what type of information will be released)

Check only one box:

☐ **Psycotherapy notes** - Federal law requires an authorization to use or release psychotherapy notes.
If you check this box, you may not check another box below.

☒ **All information related to the provision of and payment for my health care benefits or services, including coordination of care and case management services.***

☐ **Specific information described below:**

_____
Examples: The claim related to my service on (date); Appeal information related to my claim on (date)

***NOTE:** State law requires that you give specific permission to release the information below even if you checked a box above. Indicate your permission for the Health Plan to release any of the following information by initialing all that apply.

Genetic Information _____ (Initials)

HIV/AIDS _____ (Initials)

Substance/Alcohol Abuse 2 _____ (Initials)

Mental/Behavioral Health 3 _____ (Initials)

Purpose of Release: At my request
Examples: At my request; To resolve my appeal; To assist with my health insurances services.

Section E: Expiration: (when this authorization will end)**

This authorization will expire (Check ONLY ONE box):

☐ **When I revoke this authorization ***

☒ **Upon the following date, event or condition *:** Until I revoke this authorization in writing, or until my medical benefits expire.

Note: This authorization will terminate on the earliest of the events listed above or 180 days after termination of coverage.

* The party identified in section B must be notified in writing of the event/condition to cancel or revoke this authorization.

** Please note: State law requires that this Authorization to Release Information will automatically expire in 12 months for Minnesota residents and in 24 months for Montana residents unless you specify a shorter timeframe.

Section F: Approval: (You OR your Personal Representative must sign and date this form in order for it to be complete.)

I understand that this authorization to release information is voluntary and is not a condition of enrollment in this Health Plan, eligibility for benefits, or payment of claims. I also understand that if the person or organization I authorize to receive the information described above is not subject to federal health information privacy laws, they may further release the protected health information and it may no longer be protected by federal privacy laws.

Member Signature:
By signing below, I authorize the release of my protected health information as described above.

4 _____ (Print Name)

_____ (Signature of Member)

_____ (Date)

Personal Representative Information:
A personal representative is a person who has the legal authority to act on the behalf of an individual. A copy of a Power of Attorney or other legal document must be on file at the Health Plan or submitted with this form.

_____ (Printed name of Personal Representative)

_____ (Description of Representative's authority)

_____ (Date)

_____ (Signature of Personal Representative)

( ) _____ (Telephone Number)

PLEASE KEEP A COPY OF THIS FORM AND THE INSTRUCTIONS FOR YOUR RECORDS

08161 (10/16)

OVER

AUTHORIZATION FORM INSTRUCTIONS

This form must be filled out completely.

If any fields are blank or incomplete, the form will be returned.

To enable LEHB to discuss any problems or issues with billing or treatment on your behalf you must complete, sign and return this form. In addition there are special areas that require special permission. See #2 and #3 below:

1. Enter NAME, ADDRESS, BIRTH DATE, and TELEPHONE NUMBER
2. To enable LEHB to discuss Substance/Alcohol Abuse information with a provider you must initial this line.
3. To enable LEHB to discuss Mental/Behavioral Health information with a provider you must initial this line.
4. PRINT your name, and SIGN and DATE the form. The form MUST be signed or it will be RETURNED.

We completely respect your privacy. However, to enable LEHB to help insure your bills are accurately paid we must have a completed and signed copy of this form.