AUTHORIZATION FOR RELEASE AND USE OF HEALTH INFORMATION

SECTION A: MEMBER INFORMATION (person whose information you want released)

Name: (First, Middle, Last; include Jr., Sr., etc.)	**Member ID Number*:**	**Date of Birth**: (Month/Day/Year)
Address: (Include zip code)		**Telephone Number:** ( )

SECTION B: PERSON, OFFICE, OR FACILITY YOU WANT TO RELEASE YOUR INFORMATION

I authorize _____ to release my protected health information as described below in Sections C, D, E, and F.

(Name of person, office, or facility. Be specific. Example: "Landmark Healthcare, Inc.")

SECTION C: PERSON OR ORGANIZATION YOU WANT TO RECEIVE YOUR INFORMATION

Person's or Organization's Name:	**Telephone Number:** ( )

(Be specific. Examples: Dr. Karen Baker, MD; St. Mary's Medical Center; John W. Smith, Attorney; Young, Nelson & Bell Law Firm)

Address: (Include zip code)

SECTION D: SPECIFIC INFORMATION YOU WANT RELEASED

Describe or list the specific information you want released:

_____

_____

Examples: All records in Landmark's possession related to treatment in the year 20YY; Claim and payment information for treatment received between July 1, 20YY and March 31, 20YY; All information for claims that were paid on or after October 1, 20YY.

SECTION E: WHY YOU WANT THIS INFORMATION RELEASED (purpose)

_____

Examples: To resolve an appeal. To assist with my health insurance coverage. To assist my attorney.

SECTION F: EXPIRATION (when you want this authorization to end)

This authorization will expire (Check ONLY ONE box):

☐ Upon the following date, event, or condition: _____

Examples: when my coverage with Landmark ends; when my attorney settles my auto accident; the end of December 20YY

☐ When I revoke or cancel this authorization **(you must notify Landmark's Privacy Officer in writing if you wish to revoke or cancel this authorization)**

I understand my request to cancel or revoke this authorization will have no effect on information already released.

SECTION G: 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 I may refuse to sign it. My refusal will not affect my eligibility for benefits or my ability to obtain treatment or payment. I also understand that once Landmark releases my information, if the person or organization receiving it is not covered by federal privacy regulations, the privacy or my information may no longer be protected. Therefore I release Landmark and its employees from all liability for this release of my health information.
I agree that my faxed or photocopied signature will be considered as effective as my original signature.

MEMBER SIGNATURE: By signing below, I authorize the release of my or my minor child's protected health information as described above:	**PERSONAL REPRESENTATIVE INFORMATION**: A Personal Representative is a person who has the legal authority to act on behalf of an individual. A copy of a Power or Attorney or other legal or court document must be submitted or on file with the person or organization listed in Section B above.
_____ **(Print Name)**	_____ **(Print Name of Personal Representative)**
_____ **(Signature of Member)**	_____ **(Description of Representative's Authority)**
_____ **(Date)**	_____ **(Signature of Personal Representative)** _____ **(Date)**

* By law Landmark is permitted to request this number for administrative purposes and is required to protect the confidentiality of this information LHP-020513

PLEASE KEEP A COPY OF THIS FORM FOR YOUR RECORDS
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