

Authorization for Use and Disclosure of Confidential Health Information

THIS FORM WILL ALLOW LOVELACE HEALTH PLAN TO RELEASE
THE CONFIDENTIAL HEALTH INFORMATION SPECIFIED BELOW TO THE PERSONS OR ENTITIES SPECIFIED ON THIS FORM.

Description of Private Health Information to be released:

Unless otherwise indicated, my authorization includes the release of the following: (Please strike through those you wish to exclude, if any.)

- Diagnosis and/or treatment for alcoholism and/or drug abuse or dependency
- Diagnosis and/or treatment regarding mental health issues
- HIV antibody test results and/or AIDS diagnosis and treatment
- Genetic test results and/or related treatment

Identification of person authorizing release: (The following information is needed for verification. Please complete all applicable items.)

Name of Member/Participant: _____

Date of Birth: _____

Social Security #: _____

Address: (including Zip Code): _____

Member ID card number (if applicable) _____ Group or Account Number on ID card: _____

Subscriber Name (if different from Member): _____

Subscriber's Relationship to Member: _____

Subscriber's Employer Name: _____

Subscriber's Social Security Number (if different from Member): _____

If you are covered under an additional Lovelace Health Plan Policy:

Subscriber's Employer Name: _____

Number on Member ID card: _____ Group or Account Number on ID card: _____

I authorize the persons or entities below to receive the information:

Your or the Subscriber's Employer benefits representative

Your Attorney

Your Provider*

Other _____

Purpose of this release of information:

This authorization expires: _____ (to be completed by Member/Participant)
(date or event)

*If the Provider is chosen as Authorized Representative, "Appointment of Representative for Appeal" form must also be completed.
I understand that information used or disclosed based on this authorization may be subject to re-disclosure by the recipient and will no longer be protected by federal privacy regulations.

- *I understand that if information on this form is not complete, Lovelace Health Plan will return the form to me, and this request will not be considered until all information has been received by Lovelace Health Plan.*
- *I understand that I may revoke this authorization by sending a written request to the Privacy Office at the address shown below. I can obtain a form to revoke the authorization by calling Lovelace Health Plan Member services at the number on my Lovelace Health Plan ID card. Any revocation will not be effective for any actions Lovelace Health Plan has already taken.*

SIGNATURE

I have read and understand the above information:	Date: _____
Signature of Member/Participant, Parent/Guardian, Personal Representative: _____	
Relationship if person signing is other than Member/Participant: _____	
Note that, if not already provided, we will require verification of the authority of a Personal Representative before this request will be considered complete.	
If request is made by a Parent/Guardian, complete the following: Member/Participant is a minor ____ years of age. If you are making this request on behalf of a minor child, we may require additional information before this request is considered complete.	

The provision of treatment, payment, enrollment or eligibility for benefits does not depend on whether you sign this authorization. You should keep a signed copy of this authorization for your records, however, a copy of this signed authorization will be provided upon your request.
A copy of this form will be submitted to the Lovelace Health Plan Privacy Office.

To return your completed form, please:

Fax to: Lovelace Health Plan, Privacy Office at : 505-262-7719

OR

Mail To: Lovelace Privacy Office

Lovelace Health Plan

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