Authorization for Release of Protected Health Information (PHI)

Sections 1 through 9 must be completed for this authorization to be valid. *INCOMPLETE FORMS* will not be processed and will be returned to the requestor for additional information. A copy of this authorization form will be available to you, but you should retain a copy for your records.

1. MEMBER INFORMATION TO BE RELEASED

Print Name Of Member

Member Date of Birth

Member Health Plan I.D. Number

Member Address

Member Primary Phone Number

Member Secondary Phone Number

2. LUCET WILL RELEASE MEMBER INFORMATION TO

Organization or Person

Address

City, State, Zip

Primary Phone Number

Secondary Phone Number

Email Address

Fax Number

3. PREFERRED DELIVERY METHOD

☐ **Mail Information** ☐ **Email Information (If file size permits)** ☐ **Fax Information (If file size permits)**

Note: If information is shared with a person or organization that is not legally required to obey privacy laws, the information may be shared with others and may no longer be protected.

4. PURPOSE OF RELEASE

☐ Legal ☐ Insurance ☐ Healthcare provider ☐ Copies for personal use

☐ Other _____

5. INFORMATION TO BE RELEASED (Please check only one box)

☐ All information about eligibility, enrollment, plan benefits, claims, correspondence to or from Lucet and prior authorization or determinations for services provided by any physician or hospital. (INCLUDING alcohol and substance use or abuse information).

☐ All information about eligibility, enrollment, plan benefits, claims, correspondence to or from Lucet and prior authorization or determinations for services provided by any physician or hospital. (EXCLUDING alcohol and substance use or abuse information).

☐ Only specific information: _____

6. RELEASE INFORMATION PERTAINING TO THIS TIME PERIOD (Please check only one box)

☐ Any and all dates, including future dates until expiration of authorization

☐ From _____ to _____

MM/DD/YYYY MM/DD/YYYY

7. EXPIRATION OF AUTHORIZATION

Valid for one (1) year unless otherwise specified or revoked.

8. PATIENT AUTHORIZATION

I understand that:

- The information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations.
- Lucet does not condition payment, enrollment, or eligibility for benefits on whether I sign this authorization.
- I may revoke this authorization at any time by notifying Lucet. Revocation of this authorization will not affect any action taken in reliance of this authorization before the revocation was received.

If signing authorization as Power of Attorney, Power of Attorney for Health Care, or Guardian/Conservator, a copy of the legal document MUST ACCOMPANY this form.

9. SIGNATURE

_____ _____

(Member, Guardian, or Authorized Representative) Date (MM/DD/YYYY)

_____

Relationship of Authorized Representative to Member

_____ _____

Minor Signature (Signature of Minor Where Required) Date (MM/DD/YYYY)

Substance use disorder records are protected under federal law, including the federal regulations governing the confidentiality of substance use disorder patient records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Parts 160 and 164, and cannot be disclosed without written consent unless otherwise provided for by the regulations.