AUTHORIZATION FOR USE & DISCLOSURE OF HEALTH INFORMATION

Member Information:		
Name of Member:	**Member ID Number:**	**Birth Date:**
Street Address:	**City, State, Zip:**	
Phone:		

By completing and signing this form, you authorize Leon Health, Inc. to disclose protected health information to the below individuals, agencies or organizations:	
Individual(s)/agency/organization #1	**Individual(s)/agency/organization #2**
Street Address	**Street Address**
City, State, Zip Code	**City, State, Zip Code**

INFORMATION TO BE USED OR DISCLOSED:
The following is a specific description of the health information I authorize to be used and/or disclosed:

I specifically request and authorize the disclosure of the following information:
[Check all that apply]

☐ Mental Health	☐ Medical Records
☐ Enrollment and Disenrollment Information	☐ Prescription Drugs
☐ Claim Information	☐ Benefit Records
☐ Referral/Authorization Information	☐ Doctors and Hospital
☐ Benefit records	☐ Developmental Disabilities
☐ Financial	☐ Alcohol and Other Drug Abuse
☐ Diagnosis	☐ HIV Test Results
☐ Treatment	☐ Other (Specify): _____

For the following Date(s):	
From:	To:

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

Right to Receive Copy of This Authorization - I understand that if I sign this authorization, I may request a copy of this authorization.

Right to Refuse to Sign This Authorization - I understand that I am under no obligation to sign this form and that Leon Health, Inc. may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization except regarding: a) research-related treatment, b) health plan enrollment or eligibility, c) the provision of health care that is solely for the purpose of creating PHI for disclosure to a third party.

Right to Withdraw This Authorization - I understand that I have the right to withdraw this authorization at any time by providing a written statement of withdrawal to the plan's *Member Services Department.* I am aware that my withdrawal will not be effective until received by Leon Health, Inc. and will not be effective regarding the uses and/or disclosures of my health information that Leon Health, Inc. has made prior to receipt of my withdrawal statement. I understand if the authorization was obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.

Right to Inspect or Copy the Health Information to Be Used or Disclosed - I understand that I have the right to inspect or copy (may be provided at a reasonable fee) the health information I have authorized to be used or disclosed by this authorization form. I may arrange to inspect my health information or obtain copies of my health information by contacting Member Services.

Redisclosure Notice: I understand that information used or disclosed based on this authorization may be subject to re-disclosure and no longer protected by Federal privacy standards.

Expiration Date: This authorization is good until the end date noted on the previous page, or if none noted, it is valid indefinitely unless I withdraw the authorization in writing.

By signing this authorization, I am confirming that it accurately reflects my wishes.

Signature Member/Legal Rep:	**Date:**

If you are the authorized representative, you **must** provide the following information:

☐ Check here if you are signing as a personal representative and complete below. **Please attach the appropriate documentation (for example, Power of Attorney)**. This only applies if someone other than the Leon Health member signed above.

Personal Representative's Information

Name	**Relationship to Member**		**Telephone Number**
Street Address	**City**	**State**	**Zip-Code**