

INSTRUCTIONS FOR COMPLETING THE MEMBER AUTHORIZATION FORM

01	Print your last name, first name and middle initials
02	Leon Health Plans policy ID number
03	Write your date of birth in this format: mm/dd/yyyy
04	Write your full street address
05	Write your full, city, state, and ZIP code
06	Write your daytime phone number (including area code)
07	Write the full name of the person or entity that you want us to give your information to
08	Write the full street address of your authorized representative
09	Write the city, state, zip code of your authorized representative
10	This section tells us what information you would like us to release
11	Note the effective date of when this form will be valid. (MM/DD/YYYY)
12	Note the effective date of when this form will expire. (MM/DD/YYYY)
13 14	Sign your name and put the date on the form. Your name and signature must match the information in Member Information.
01	This section should only be filled out if you're signing as a personal representative, who has a legal representation, like a Power of Attorney. (Otherwise this section must be left blank.)

Member Information: Name of Member: Member ID Number: 13	mber: 02 Member ID Number: 03 Birth Date: ss: 05 City, State, Zip: 19 and signing this form, you authorize Leon Health, Inc. to disclose protected nation to the below individuals, agencies or organizations: 10 Individual(s)/agency/organization #2 11 Individual(s)/agency/organization #2 12 Street Address 13 Street Address 14 City, State, Zip Code 15 Street Address 16 Code 17 ORE USED OR DISCLOSED: 18 a specific description of the health information authorize to be used and/or disclosed: 18 request and authorize the disclosure of the following information: 18 at apply) 18 dedical Records	THORIZATION FOR USE & DISCI	LOSURE OF HEALTH INFORMATION		
Street Address: 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 Street Address 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 discl. I specifically request and authorize the following information:	City, State, Zip: City, State, Zip Code City, State, Zip Code	fember Information:			
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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 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 disclined in the following information:	ing and signing this form, you authorize Leon Health, Inc. to disclose protected nation to the below individuals, agencies or organizations: Agency/organization #1	treet Address:	and the same of th		
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☐ Financial ☐ Alcohol and Other Drug Abuse	□ Developmental Disabilities □ Alcohol and Other Drug Abuse	→ Diagnosi5	☐ Other (Specify):		
☐ Financial ☐ Alcohol and Other Drug Abuse	□ Developmental Disabilities □ Alcohol and Other Drug Abuse				

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, of 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 <u>must</u> 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

Relationship to Member		Telephone Number
City	State	Zip-Code
		•

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AUTHORIZATION FOR USE & DISCLOSURE OF HEALTH INFORMATION

Member Information:					
Name of Member: Member ID N) Num	ber:	Birth Date:	
Street Address: C			, State, Zip:		
Phone:					
By completing and signing this health information to the below					
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 OF The following is a specific descrip			formation I autho	orize to be used and/or disclosed:	
I specifically request and author [Check all that apply]	orize the disc	closur	e of the followir	ng information:	
☐ Mental Health			☐ Medical Re	cords	
☐ Enrollment and Disenrollment Information			☐ Prescription	n 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 (Spec	cify):	
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.

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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 <u>must</u> provide the following int	l formation:
Check here if you are signing as a personal representative and compleattach the appropriate documentation (for example, Power of Attorne) 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