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

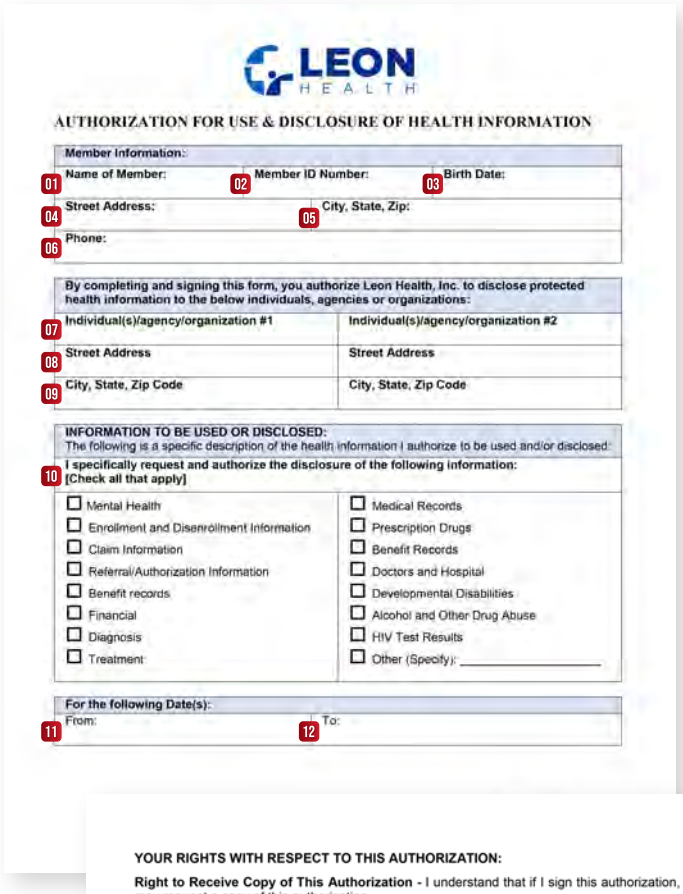
10 This section tells us what information you would like us to release

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.)



LEON HEALTH

AUTHORIZATION FOR USE & DISCLOSURE OF HEALTH INFORMATION

Member Information:

01 Name of Member: | 02 Member ID Number: | 03 Birth Date:

04 Street Address: | 05 City, State, Zip:

06 Phone:

By completing and signing this form, you authorize Leon Health, Inc. to disclose protected health information to the below individuals, agencies or organizations:

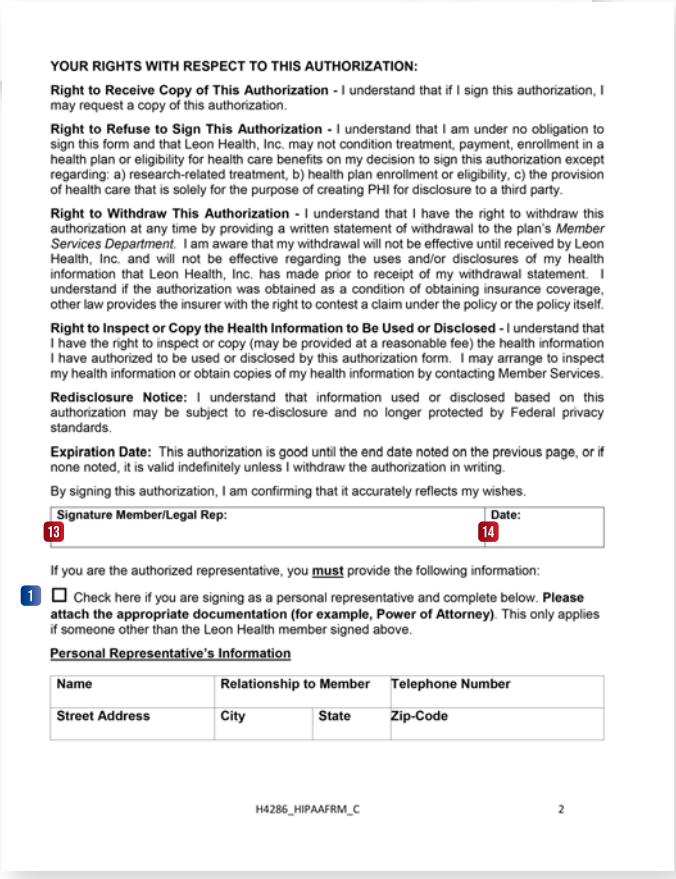
07 Individual(s)/agency/organization #1	Individual(s)/agency/organization #2
08 Street Address	Street Address
09 City, State, Zip Code	City, State, Zip Code

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

10 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):
11 From: | 12 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.

13 Signature Member/Legal Rep: | 14 Date:

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

1 ☐ 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

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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:

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Street Address	**City**	**State**	**Zip-Code**