## Authorization To Use/Disclose Protected Health Information

## Release by Lasso Healthcare Medicare Advantage Plans to a Third Party

**THIS AUTHORIZATION FORM MUST BE COMPLETED IN FULL FOR IT TO BE VALID.**

**Member:_______________________________________ID #______________________________________**

I authorize: **Lasso Healthcare Medicare Advantage Plan** to disclose my protected health information to:

**Name:_______________________________________________________________________________**

**Address:_____________________________________________________________________________**

for the purpose(s) of:___________________________________________________________________________

**ALLOW RELEASE OF THE FOLLOWING TYPES OF INFORMATION (check all that apply):**

___________Premium Information ___________Claim Information

___________Benefit Information ___________Enrollment Information

___________Other (Please Specify)__________________________________________________________

If you wish to specify a date range or limit the type of information for the above options, please list below:

_________________________________________________________________________________________

_________________________________________________________________________________________

**PERMISSION TO ACT ON MY BEHALF to:**

__________Change my address

__________Enroll me/disenroll me

__________Do and perform all acts necessary as I might do (including but not limited to the above items)

*(Describe each additional purpose of the use/disclosure):*

_________________________________________________________________________________________

_________________________________________________________________________________________

_________________________________________________________________________________________

_________________________________________________________________________________________

My protected health information includes medical records, emergency and urgent care records, billing statements,

diagnostic imaging reports, transcribed hospital reports, clinical office chart notes, laboratory reports, dental records, pathology reports, physical therapy records, hospital records (including nursing records and progress notes), and any personal or medical information related to the purpose of this Authorization. Information obtained with this Authorization will be used solely for the purpose defined above and will be limited to the minimum necessary information to achieve that purpose.

If the information to be disclosed contains any of the types of records or information listed immediately below, additional laws relating to use and disclosure of the information may apply. **I understand and agree that such information will be disclosed if I place my initials in the applicable space** next to the type of information to be included with the disclosure:

______Sexually Transmitted Diseases/HIV/AIDS test or result information and related records
______Mental health information
______Genetic testing information (Genetic information is not collected or used for underwriting or enrollment purposes.)
______Drug/alcohol diagnosis, treatment, or referral information
______Reproductive health information

**I understand that I have the right to refuse to sign this Authorization. My refusal to sign this Authorization will not affect my enrollment in Lasso Healthcare Medicare Advantage Plan or eligibility for health plan benefits.**

**I have the right to revoke this Authorization in writing at any time. If I revoke my Authorization, the information described above will no longer be used or disclosed for the reasons stated on this written Authorization. Any uses or disclosures already made with my Authorization cannot be taken back. After the company gets my notice, the Company will cancel this release within five (5) business days. I understand that the Company may already have shared some or all of my information and that the Company will not be liable for any information already released.**

**To revoke this Authorization, please send a written statement to Lasso Healthcare Medicare Advantage Plans at P.O. Box 261113, Plano, TX 75026 and state that you are revoking this Authorization. Please include a copy of the original Authorization if available. Otherwise, please include the name of the party receiving the protected health information and the date of the Authorization.**

I understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure and no longer be protected under federal law. However, I also understand that federal or state law may restrict re-disclosure of HIV/AIDS test or result information, mental health information, genetic information and drug/alcohol diagnosis, treatment or referral information.

**This authorization will remain effective until otherwise revoked.**

**I have reviewed and I understand this Authorization.**

**By:**________________________________________ **Date:**________________
**(Individual)**

**- OR –**

**By:**________________________________________ **Date:**________________
**(Individual's representative)**

**Relationship to member:** ☐ **Parent** ☐ **Legal guardian*** ☐ **Holder of Power of Attorney***

***Please attach legal documentation if you are the legal guardian or Holder of Power of Attorney**

Once you have completed this form, please mail to:

Lasso Healthcare Medicare Advantage Plan
P.O. Box 261113
Plano, TX 75026

Thank you,
Lasso Healthcare