Lucent Health

Form Completion Instructions:

1. Affected employee or adult dependent should complete all information below.
2. Return completed form as specified below.
3. Access will be provided within 30 days upon receipt of form.

Group #: _____

Group Name: _____

AUTHORIZATION TO RELEASE INFORMATION

SECTION A: The Individual (or the Individual's Personal Representative) Confirming the Authorization

I authorize the use and/or disclosure of my protected health information. I understand this authorization is voluntary and made to confirm my direction. I understand that, if the persons or organizations I authorize to receive and/or use the protected health information described below are not health plans, covered health care providers or health care clearinghouses subject to federal health information privacy laws, they may further disclose my protected health information and it may no longer be protected by federal health information privacy laws.

Employee or Adult Dependent: _____ Date of Birth: _____

Employee ID Number: _____ Telephone: _____

Address: _____

City: _____ State: _____ Zip Code: _____

SECTION B: The Use and/or Disclosure Being Authorized

Protected Health Information to Be Used and/or Disclosed: Information related to financial terms, diagnoses, procedure(s) completed, provider(s) used and dates of service.

Entities currently authorized to Use or Disclose: The Benefit Plan

Entities Authorized to Receive and Use Protected Health Information: Name the person(s) to whom you are authorizing The Benefit Plan to disclose and/or let use the protected health information described above. Please include your relationship to the person(s) in question as well as the level of access the person(s) will have.

Name: _____

Name: _____

SECTION C: Expiration and Revocation

This authorization will expire upon my specific written request.

Right to Revoke: I understand that I may revoke this authorization at any time by giving written notice of my revocation to the contact person provided below. I understand that my revocation will be effective when Lucent Health receives it and that my revocation of this authorization will not affect any action Lucent Health took in reliance on this authorization before receiving my written notice of revocation.

SECTION D: Employee or Adult Dependent (same as Section A)

I _____, have had full opportunity to read and consider the contents of this authorization, and I confirm that the contents are consistent with my direction to Lucent Health. I understand that, by signing this form, I am confirming my authorization that Lucent Health may use and/or disclose to the persons and/or organizations named in this form, the protected health information described in this form.

Employee or Adult Dependent (please print): _____

Employee or Adult Dependent signature: _____ Date: _____

Return completed form to:

Lucent Health
Attn: Group Administration Dept.
P O Box 7020
Appleton, WI 54912-7020
Phone: 877-236-0844 Fax: 866-542-1874