Form LG17
Revised 10/14

LOCAL GOVERNMENT HEALTH INSURANCE PROGRAM

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

This authorization will permit the Local Government Health Insurance Board (LGHIB) to disclose your health information that you describe below ("Protected Health Information") to the persons or entities and for the purpose that you describe below. **Please read and complete the following, and return to Local Government Health Insurance Board, P O Box 304900, Montgomery, Alabama 36130-4900.**

A. The Individual Who is The Subject of the Protected Health Information.

NOTE: A separate authorization form must be completed by each individual (or his/her personal representative) who desires to request that the LGHIB disclose his/her Protected Health Information as described in this authorization.

Name	Date of Birth	Contract Number	Social Security Number
Address			**Telephone Number**

B. Description of My Protected Health Information to be Disclosed.

Note: Please insert your initials in front of the paragraph below (1, 2 or 3) that applies to the description of your Protected Health Information to be disclosed pursuant to this authorization. If you initial paragraph 2 or 3, please complete the blanks below that paragraph.

1. _____ ☐ Any or all of my Protected Health Information that may be requested from time to time by the person(s) I identify in Section D below.

2. _____ ☐ All my Protected Health Information related to one or more of the following:

Description of Claim _____

Timeframe(s) of Service _____

Name of Provider _____

3. _____ ☐ Other. Here is a specific description of my Protected Health Information to be disclosed.

_____

_____

C. Person(s) Authorized to Disclose My Protected Health Information.

By signing this authorization, I hereby authorize the LGHIB to disclose my Protected Health Information.

D. Person(s) Authorized to Receive My Protected Health Information.

Name _____

Address _____

Telephone _____

E. Purpose of This Disclosure of My Protected Health Information (select one).

☐ **At my request** ☐ **Other (please specify) _____**

F. Date of Expiration of this Authorization (select one).

☐ **Until my coverage under my Health Plan (identified by the Contract Number on front) terminates.**

or

☐ **Expiration Date _____ If no expiration date is indicated, this authorization will expire in 90 days from the date of this authorization.**

G. Right to Revoke this Authorization.

I understand that I may revoke this authorization at any time by giving written notice of my revocation to the address listed below. I understand that revocation of this authorization will not affect any action taken in reliance on this authorization before you received my written notice of revocation.

LOCAL GOVERNMENT HEALTH INSURANCE BOARD
ATTENTION: PRIVACY OFFICIAL
P O BOX 304900
MONTGOMERY, ALABAMA 36130-4900

H. Signature:

By signing this authorization, I understand that my Protected Health Information described herein may be re-disclosed by the person(s) I have authorized to receive and use my Protected Health Information and that my Protected Health Information described herein may no longer be protected by federal privacy laws.

I, _____, have had full opportunity to read and consider the contents of this authorization.

Signature _____ Date _____

***Personal Representative Signature _____ Date _____**

*If signed as a Personal Representative, you must describe your authority to act as the Personal Representative of the individual who is the subject of the Protected Health Information described in this authorization ("Individual") **by initialing one of the following:**

_____ The individual is an un-emancipated minor child, I am the parent and have authority under applicable law to act on behalf of the individual in making decisions related to health care, and the health information described herein is relevant to my personal representation of the individual. **Please note: You should consult your state's laws to find out if you have legal authority to make health care decisions for your child. If you are unsure whether you have such legal authority, both you and your child must sign this authorization.**

_____ The individual is an adult, un-emancipated minor or emancipated minor, I am the guardian, attorney-in-fact or other authorized representative and have authority under applicable law to act on behalf of the individual in making decisions related to health care, and the health information described herein is relevant to my personal representation of the individual. **Attached is a copy of the legal document(s) that give me authority to act as a Personal Representative, such as letters of guardianship.**

_____ The individual is deceased, I am the executor, administrator or other person authorized under applicable laws to act on behalf of the individual's estate, and the health information described herein is relevant to my personal representation of the individual or the individual's estate. **Attached is a copy of the legal document(s) that give me authority to act as a Personal Representative, such as letters testamentary or letters of administration.**

PLEASE RETAIN A COPY OF THIS AUTHORIZATION FOR YOUR RECORDS AFTER YOU SIGN IT.