PLEASE SIGN and RETURN

AUTHORIZATION TO DISCLOSE PERSONAL HEALTH PLAN INFORMATION

Your name, address, date of birth, social security number, payroll number, and telephone number are Protected Health Information under federal law.

This form is used to release protected health information as required by federal and state privacy laws.

This authorization allows Law Enforcement Health Benefits to release contact information to entities that have signed a Business Associate Agreement in accordance with 45 CFR 164.502(e).

I authorize the release of the protected health information listed below only. I understand the signing of this form limits the release of my protected health information to the persons or organizations listed below. I understand that I can revoke this authorization at any time by submitting a request in writing to any of the affected organizations and that my consent is not needed for release of this information for medical purposes within the FOP organized health care arrangement ("OHCA"), including Law Enforcement Health.

Revoking this authorization will not affect any action taken prior the receipt of the request.

Please PRINT

Member Information

Name: (First, Middle, Last, Title)	**Date of Birth: (Month/Day/Year)**
Address:	**Telephone Number: (including area code)**
City, State, Zip:	**RESIDENT District:**

Group Name/Number:	**Social Security Number:**	**Member Payroll Number:**

Organization (That will release my information)

- LEHB

Receipt (organizations that will receive my information)

- LEHB Authorized Business Associates

Description of the information to be released and limited to

- Name
- Address
- Date of Birth
- Social Security Number
- Payroll Number
- Telephone Number

Purpose of release

- To change my address at LEHB. (Note: This form does not change your address at any other organizations.)

Expiration

- This authorization will expire one year from the date of this signature or, if earlier, when I revoke it or provide a new form.

Approval

- I understand that this authorization to release is voluntary and is not a condition of enrollment in any organization, eligibility for benefits, or payment of claims.

Member Signature

By signing below, I authorize release of my name, address, date of birth, social security number, payroll number, and telephone number to LEHB Authorized Business Associates.

Member Signature

Dated: _____	_____ Signature