Authorization to Release Information to My Representative

I authorize ____to provide information to the following person(s):

____

Name(s) Address(es) Phone #(s)

____

Relationship *(Spouse, Parent, Employer, Legal Representative, Personal Representative or Other)*

Please provide a description of the information to be disclosed or the issue to be addressed:

____

____

____

By signing this form,

- I limit this authorization to only the dates of service specified above or only to the issue or problem described above. Furthermore, I acknowledge that this authorization will last until the termination of my membership with ________________ or until the resolution of this problem or issue, whichever is earlier.
- I understand that I can revoke this authorization at any time by writing to the Privacy Officer at Local Government Center (LGC) HealthTrust.
- I know that my enrollment with LGC HealthTrust is not conditioned on giving this authorization.
- I understand that the information used or disclosed pursuant to this authorization may be subject to the re-disclosure of information to other parties necessary for resolution or communication of this issue.

____

Your Name *(printed)*
____

Your Signature
____

Your LGC HealthTrust Identification Number
____

Date

If a legal representative signs on behalf of the individual, a copy of the legal representative's authority (e.g., Health Care Power of Attorney, Executor/Administrator of an estate) must be attached to this form.