

The purpose of the requested disclosure:

At my request*	Personal use
Continued medical care	Insurance claim
Insurance application	Social Security/Disability determination
Military	School
Legal purposes	Other (please specify) _____

*This option is the sufficient description when an individual initiates the authorization and does not, or elects not to, provide a statement of purpose.

Expiration date:

This authorization shall remain valid (unless revoked in writing) until:

One year from the date I sign it

The following date: _____

Until the following event occurs: _____

Signature

By signing below, I acknowledge understanding that:

1. I may revoke this authorization at any time in writing, and upon request, St. Luke's Health Plan will furnish me with a form to make my written revocation, but I am not required to use that form to make my written request for revocation.
2. My revocation will not apply to the information that has already been released as permitted by this authorization.
3. St. Luke's Health Plan may not condition my treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization.
4. The person(s) to whom this information is disclosed may re-disclose the information, and it will no longer be protected by federal health information privacy law.
5. I have a right to request and receive a copy of this authorization.

**I have read and understand this Authorization for Release Protected Health Information (PHI),
I have signed the form voluntarily and have received a copy of it:**

Name: _____ **Signature:** _____

Relationship to member: _____

Verification (Internal Use Only)

Identity of individual verified

Identity of Representative and their authority to act verified

Received and confirmed for St. Luke's Health Plan by:

Signature: _____ **Date:** _____

Name of employee: _____

Email the form to customerservice@slhealthplan.org. For questions, call **833-840-3600**.