Request for Authorization

For Use and Disclosure of Protected Health Information

I hereby authorize Liviniti, LLC and any of its parent companies, subsidiaries, and affiliates and their respective employees, agents, and subcontractors, to disclose Protected Health Information (PHI) concerning the Member identified in Section 1 below. **I understand this authorization is voluntary and may be revoked at any time.**

1. Member Information

First Name:	Middle Name:	Last Name:	
Street Address:	City:	State:	Zip:
Cardholder ID:	DOB (MM/DD/YYYY):	Cell Phone (include area code):	Home Phone (include area code):
E-mail Address:	Plan Sponsor/Employer Group:		

2. Cardholder Information

(The Cardholder is usually the Employee who obtains coverage for their family. Only complete this section if Cardholder is not the Member whose records are being requested.)

First Name:	Middle Name:	Last Name:	
Street Address:	City:	State:	Zip:
Cardholder ID:	DOB (MM/DD/YYYY):	Daytime Phone (include area code):	
E-mail Address:	Plan Sponsor/Employer Group:		

3. Individual(s) or Company(ies) authorized to receive PHI pertaining to Member in Section 1

Individual or company authorized to receive PHI:	Daytime Phone (include area code):	Contact Name:	
Street Address:	City:	State:	Zip:
Individual or company authorized to receive PHI:	Daytime Phone (include area code):	Contact Name:	
Street Address:	City:	State:	Zip:
Individual or company authorized to receive PHI:	Daytime Phone (include area code):	Contact Name:	
Street Address:	City:	State:	Zip:

Contact Us: support@liviniti.com

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4. Purpose for this authorization

(The purpose for this authorization is to permit disclosure of any requests for PHI.)

This authorization is made at my request. OR
Other Purpose (Legal, Medical, etc.): _____

The Personal Health Information about me that may be used and/or disclosed includes, but is not limited to, any information held by Liviniti, LLC and/or affiliates for any time period about my:

- Treating providers of care (pharmacies, prescribing physicians, etc.);
- Prescription records (drug names, dispensing dates, costs, etc.);
- Demographic information (address, etc.); and
- Eligibility information (dates of coverage, deductibles, etc.).
- Other specific information: _____

My authorization includes the release of the following sensitive health information:

- Diagnosis and/or treatment for alcoholism and/or substance abuse or dependency
- Diagnosis and/or treatment regarding mental health issues
- HIV antibody test results and/or diagnosis and related treatment
- Genetic test results and/or related treatment

By signing this form below, I understand and agree to the following:

- I authorize the recipient(s) listed above in Section 3 to receive my personal information which may include PHI. I also understand that unless otherwise requested to do so in writing, the recipient(s) authorization will expire in twelve (12) months from the date signed or upon termination of enrollment in the health plan.
- I understand that I may reassign or revoke this authorization at any time by giving written notice of my changes to Livinitis' Member Services Department to the address listed at the bottom of this form. Revoking this authorization will not have any effect on actions that Liviniti or other parties took with my permission before receiving my notice to revoke the authorization.
- My PHI that I authorize to share may be sensitive. It may include Information relating to the treatment of chronic diseases, behavioral health conditions, reproductive health, and substance abuse. It may also include treatment for communicable diseases and sexually transmitted diseases such as HIV/AIDS.
- I understand that information used or disclosed based on this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal privacy regulations.
- My treatment, enrollment and eligibility for benefits, and payments for services will not be affected If I do not sign this authorization.
- I should keep a copy of this authorization for my records; however, I may receive a copy of this signed authorization if I request to do so in writing to the address listed at the bottom of this form.

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Print Member Name (or Authorized Representative):	
Member Signature (or Authorized Representative):	Date (MM/DD/YYYY):
Relationship to Member if signed by Authorized Representative (Parent/Legal Guardian, Legal Representative, Court Order, Other - please explain):	

Witness - Print Name (for Illinois residents only):	
Witness - Signature:	Date (MM/DD/YYYY):

Please return the completed form to:

Liviniti

Attn: Member Services

PO Box 2482

Natchitoches, LA 71457

OR

Email: support@liviniti.com

OR

Fax: (318) 214-4190