Lifeline Alliance®
HealthShare

Medical Release

Members's name

First name | M.I. | Last name

Date of birth Month / Day / Year

For benefits-related purposes of the Lifeline Alliance Long Term Care benefits program (LTCBP), including determining eligibility for benefits, care coordination, benefits decision-making, coordinating benefits with insurance companies or payers, benefits payment, benefits appeals, and benefits management activities, I authorize any licensed health care practitioner, medical facility, employer, insurance company, or any other entity or person that has any health information about me to give that health information to Lifeline Alliance, and their subcontractors who need to know health information to provide contracted services.

The health information I am permitting to be disclosed and used for the LTCBP includes any information on my medical history, and the diagnosis, prognosis, and treatment of any physical or mental condition. It includes the disclosure of any medical care or surgery, psychiatric or psychological care or examinations, and information about alcohol or drug use (including any information otherwise protected by Federal Regulations 42 CFR Part 2 or other applicable laws).
I understand that this authorization includes my consent to use and disclose medical information that relates to mental illness, HIV, AIDS, HIV-related illness, and sexually transmitted diseases or other serious communicable diseases, but only in accordance with any law or regulation that applies to any such disclosure of this information about me.

I understand that:

- If I do not sign this authorization, any eligibity for long term care benefits may be denied.
- I may revoke this authorization at any time, except to the extent that
  - Action has already been taken on reliance on it prior to my revocation, or
  - Lifeline Alliance has a right to contest my long term care benefits
- If I do revoke this authorization, I understand that any claim for long term care benefits may be denied.
- To revoke this authorization, I must notify **Lifeline Alliance 456 A Central Ave, Suite 157 Cedarhurst, NY. 11516**, in writing.
- If I do not revoke this authorization, it will be valid from the date I sign it to the date the benefits are closed.
- My health information may be redisclosed and no longer protected by applicable law, including federal health information privacy regulations. This can occur only if such redisclosure is required or allowed by law (e.g., in response to a subpoena).
- A copy of this authorization is as valid as the original.

Members's signature _____ Date signed ____/____/____
(Required: mm/dd/yy)

If the member is unable to sign for him- or herself, please include a copy of the durable financial power of attorney or guardianship papers, if not already submitted.

Legal representative's signature _____ Date signed ____/____/____
(Required: mm/dd/yy)

Return your completed form to:

Lifeline Alliance 456 A Central Ave, Suite 157 Cedarhurst, NY. 11516,

Fax : 800-984-5524