



Authorization for LifeMap to Release Information form Instructions

What is a disclosure authorization form?

There may be situations when you want someone to help you with questions or concerns about your benefits, claims, premium and billing information, or you beneficiary information. This includes times when you may not be able to contact us directly. The form gives LifeMap permission to speak with others, you authorize, on your behalf.

Does it expire?

Your authorization automatically expires two years after the date you sign it. You may also withdraw a submitted authorization at any time.

Who can be listed as an approved contact?

A spouse, family member and/or friend.

The form is not required for LifeMap to speak with your healthcare providers; an insurance company; and/or your personal legal representative, such as your power of attorney.

Do I need to include legal documentation with it?

Please include full legal documentation only if signature is provided by your legal representative (e.g. Attorney in Fact, guardian or conservator).

How do I access the form?

You can access the form online through our website.

1. Go to <https://www.lifemapco.com/forms>
2. Choose the **Authorization for LifeMap to Release Information** form from the list.
3. Click on the Download form link next to the pdf icon.

How do I return the form?

The completed form may be returned by:

Email: Authorization@LifeMapCo.com

Fax: 1 855-733-4615

Mail: LifeMap
200 SW Market Street, Suite 800
Portland, OR, 97201

What information do I need to include?

Your full name as it appears on your member ID card or policy document(s); Your LifeMap ID, which may be either your Member ID, Claim # or the last four digits of your Social Security Number; Your Date of Birth.

The names of the people or entities you want to have access to your information, their address and for what purposes.

Check the boxes for the information you want LifeMap to be able to discuss:

- **Enrollment, eligibility, benefit information:** Open enrollment, benefits, information on getting signed up, status of member ID cards
- **Medical information:** Chart notes, x-rays, operative reports, lab and medication records and all the medical information about you, including medical history, diagnosis, testing and test results.
- **Alcohol/substance abuse:** Alcohol and substance use, counseling or treatment.
- **Claims, claim status, and claim history:** All information about benefits paid or payable including amounts and offsets, payment dates, payment periods, any scheduled reduction or termination of my claim(s), confirmation if a claim was received, information about past providers and services completed by a provider. Additionally, may include non-medical information such as education, employment history, earnings or finances etc.
- **Premium and billing information:** Deductible or out-of-pocket information, premiums and copays.
- **Appeals:** Appeal of any claim determination with which you disagree.
- **Other:** Anything that falls in between categories or is better described differently.

What if I don't want to authorize anyone else to speak with LifeMap on my behalf?

We won't disclose your information without your permission. If you don't want us to speak to anyone on your behalf, you don't have to complete and return the form.

Authorization for LifeMap to Release Information

Full Name _____

LifeMap ID# _____

Date of Birth _____

If you have more than one LifeMap insurance policy, we will apply this authorization to all policies.

I AUTHORIZE LifeMap Assurance Company (LifeMap) to disclose the following of information:

Enrollment, eligibility, benefit information

Claims, claim status, and claim history

Medical records and diagnosis

Premium and billing information

Alcohol/substance abuse*

Appeal

Other _____

This information may contain sensitive data, including data related to treatment of sexually transmitted diseases, HIV/AIDS, mental health, reproduction or contraception (including prenatal care and abortion), gender dysphoria, gender affirming care, and domestic violence.

I authorize LifeMap to disclose the information identified above to the following person(s) or entity(ies):

Name _____

Name _____

Relationship _____

Relationship _____

Address _____

Address _____

Phone _____

Phone _____

You must choose one:

The purpose of this disclosure is: to assist me with my insurance plan **OR** other _____

This authorization is valid for two years from the date of my signature. I may cancel this authorization at any time by sending written notice to LifeMap, 200 SW Market Street, Suite 800, Portland, OR, 97201 or Authorization@LifeMapCo.com. Cancellation of this authorization will not affect any actions taken by LifeMap before receiving my cancellation notice. I understand completing this authorization is not a condition to receive treatment, payment, enrollment or eligibility. LifeMap is not responsible for any action taken by an authorized recipient of my protected health information. I am aware that once LifeMap discloses my information to an authorized recipient the privacy protections provided by law may no longer apply.

Signed _____

Date (mm/dd/yyyy) _____

If you are signing this authorization on behalf of another individual, please complete the following and attach documentation demonstrating your authority to act on behalf of the individual. (e.g., power of attorney, conservatorship, etc.).

Name of Personal Representative (please print)

Phone

Relationship

Signature of Personal Representative

Date (mm/dd/yyyy)

***NOTE:** I understand that my substance abuse records are protected under Federal law (42 CFR Part 2) and cannot be disclosed without my written consent unless otherwise provided for in 42 CFR Part 2. I also understand that I may cancel this approval at any time, as described above.

Return this form to: LifeMap, 200 SW Market Street, Suite 800, Portland, OR, 97201 or Authorization@LifeMapCo.com