HIPAA Form Instructions

By law, the Plan can only speak directly to you about your health information or your Plan information unless you provide consent for us to speak with someone else. Please complete the attached HIPAA form if you would like the Plan to be able to speak to another person on your behalf. If you have a Power of Attorney or a Guardian, you should also identify them on this form. Please attach any Power of Attorney or Guardianship paperwork to the form for our records. If you have any questions, please contact us at customerservice@lifeworksadvantage.com or 1-844-854-6883.

Return your completed HIPAA form via:
Email: Enrollment@lifeworksadvantage.com
Mail: PO Box 2190
Glen Allen, VA 23058-2190

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HIPAA Right of Access Form for Family Member/Friend

I, _____, direct my health plan, health care and medical services providers to disclose and release my protected health information described below to:

Name: _____

Relationship: _____

Contact Information:

_____

Health Information to be disclosed upon the request of the person named above: (Check either A or B)

☐ A. **Disclose** my complete health record (including but not limited to diagnoses, lab tests, prognoses, treatment, and billing, for all conditions) **OR**

☐ B. **Disclose** my health record, as above, **BUT do not disclose** the following (check as appropriate):

- ☐ Mental health records
- ☐ Communicable diseases (including HIV and AIDS)
- ☐ Alcohol/drug abuse treatment
- ☐ Other (please specify):

_____

Form of Disclosure (unless another format is mutually agreed upon between my provider and designee):

- ☐ An electronic record or access through an online portal
- ☐ Hard copy

This authorization shall be effective until (Check one):

- ☐ All past, present, and future periods OR
- ☐ Date or event: _____

unless I revoke it. (**NOTE:** You may revoke this authorization in writing at any time.)

_____ _____

Name of the Individual Giving this Authorization **Date of birth**

_____ _____

Signature of Individual Giving this Authorization **Date**

_____

Relationship to Patient/Member

Note: If the Individual giving this authorization is not the patient/member, please provide supporting documentation authorizing the Individual to receive the patient/member's health information.

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