Lifeline Alliance®
HealthShare

LTCBP Authorization for Disclosure of Information

If you would like to authorize us to speak to a designated person about your benefits, please complete the following and mail it back to us in the enclosed postage-paid envelope.

Until we have received this authorization form or a copy of your durable financial power of attorney or guardianship papers (as determined by your state of residence), we will not be able to discuss your benefits with anyone other than you (including your spouse). Note: The type of power of attorney will determine the authorization your designated person has on your behalf. For example, we cannot share specific policy information or act on instructions from your designated person with regard to your benefits if your representative only has a health care power of attorney or a health care proxy.

Member's name

First name | M.I. | Last name

Address

City | State/Territory

Country | Zip/Foreign postal code

Date of birth ☐☐ / ☐☐ / ☐☐
Month / Day / Year

I, the member named above, authorize Lifeline Alliance Corp, to disclose information about my Long Term Care Benefits Program (LTCBP), including demographic information, billing and payment information, claim and related medical information, and other information related to the LTCBP, to the person(s) listed below. This will allow that person(s) to assist me in matters related to my benefits under the LTCBP.

Name _____ Relationship _____ Phone number ☐☐☐ - ☐☐☐ - ☐☐☐☐

Name _____ Relationship _____ Phone number ☐☐☐ - ☐☐☐ - ☐☐☐☐

I understand that this authorization is voluntary. Unless I revoke the authorization, I understand that it is valid until the later of 1) one year from the date this form is signed or 2) one year from the date I no longer have benefits under the applicable account (if I am insured or become insured), at which time it will expire. I understand that I may revoke this authorization at any time by notifying Lifeline Alliance in writing at: **Lifeline Alliance 456 A Central Ave, Suite 157 Cederhurst, NY. 11516** . Revoking this authorization will have no effect on any information released in reliance on this authorization before Lifeline Alliance received the revocation. I further understand that Lifeline Alliance will not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization.

I understand that the individual(s) listed above may redisclose any information received. Once information is disclosed to the individual(s), I understand that the information may no lo nsurance Portability and Accountability Act (HIPAA) regulations and other applicable privacy laws.

Signature (member or legal representative)_____

Date Signed _____ / _____ / _____
(Required : mm / dd / yy)

If signed by a personal representative of the member, please describe the authority under which the personal representative is authorized to act and enclose any related documentation (e.g., copy of your durable financial power of attorney):

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