LifeMap Assurance Company®
200 SW Market Street
P.O. Box 1271, MS E-8L
Portland, OR 97207-1271
(800) 756-4105

Authorization for Use and Disclosure of Protected Health Information

I authorize any physician, health care provider, hospital, insurance or reinsurance company, or other insurance information exchange to disclose to LifeMap Assurance Company (LifeMap) or its representatives health information (including alcohol, chemical dependency, mental health treatment, genetic testing or HIV treatment) pertaining to me and/or my eligible dependents. I acknowledge and understand that this information will only be used for the purpose of determining enrollment in the health plan and eligibility for benefits or payment of claims. Health information may include claims records, correspondence, medical records, billing statements, diagnostic imaging reports, laboratory reports, dental records, or hospital records (including nursing records and progress notes).

If I choose to not sign this authorization, LifeMap may be unable to enroll my family or me in the health plan or to pay claims that were incurred while we had insurance coverage with LifeMap.

I may cancel this authorization at any time by sending a written request to LifeMap. Cancellation of this authorization will not affect any action LifeMap took before it received this request. If I do not revoke this authorization, it will automatically expire when I am no longer covered under this policy and all claims arising from the policy have been settled, or in 24 months from the date below, whichever comes first. A photocopy of this authorization is as valid as the original.

Federal law requires LifeMap to tell me that if the party to whom LifeMap discloses my personal information shares it with anyone else, some state and federal laws may no longer protect it. This excludes alcohol and drug abuse records, which are protected by federal confidentiality rules (42 CFR, part 2). Federal law prohibits redisclosure of this information without specific written authorization.

INSURED'S NAME: (Please print) _____ **DOB:** _____

INSURED'S SIGNATURE*: _____ **DATE:** _____

*If signature by a personal representative of the Insured, please complete the following:

Personal Representative's Name: _____

Relationship to Insured: ☐ Parent ☐ Legal Guardian* ☐ Holder of Power of Attorney*

*Please attach legal documentation if you are the Legal Guardian or Holder of Power of Attorney.

Please send my records to:

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_____ **(initials)** I specifically give authorization to my provider to FAX my medical information to LifeMap.
Medical Records can be faxed to Lifemap at 1 (855) 207-1205

THIS AUTHORIZATION MAY NOT BE USED FOR PSYCHOTHERAPY NOTES
(Notes recorded and separately maintained by a mental health professional documenting or analyzing the contents of conversation during a counseling session.)