Lumicera® Infusion Services

AUTHORIZATION TO PERMIT DISCLOSURE OF HEALTH INFORMATION

Patient Name _____ **Date of Birth** _____

Patient Address _____

This disclosure can be used for the following reasons:

- ☐ Resolution of Claims Billing
- ☐ Insurance Eligibility and/or Benefit Information
- ☐ Other: _____
- ☐ Coordination of Care for Dependent/Spouse
- ☐ To Enroll/Coordinate Program Assistance

I AUTHORIZE THE DISCLOSURE OF MY PROTECTED HEALTH INFORMATION BY LUMICERA HEALTH SERVICES TO THE FOLLOWING:

Individual or Entity Name	
Address	
City, State, Zip	
Relationship to Patient	☐ Spouse ☐ Parent ☐ Child ☐ Sibling ☐ Other _____

☐ Patient Support / Copay / Financial Assistance Program	
Drug	
Program	
Manufacturer / Hub	

The following information should be disclosed from my record: *(Select one option)*

- ☐ Entire Record
- ☐ Specific Drugs (Specify): _____
- ☐ Personal and Drug Information for Enrollment/Participation in Patient Copay/Financial Program
- ☐ Specific Date Range (Specify):_____
- ☐ Other (Specify):_____

Optional: The sensitive info below should be included in the disclosure to an individual/entity: *(Select all that apply)*

- ☐ Alcohol/Drug Abuse Treatment
- ☐ Sexually Transmitted Diseases
- ☐ Mental Health Treatment
- ☐ HIV/AIDS Related Treatment
- ☐ Other (specify): _____

Authorization is terminated: *(Select all that apply)*

- ☐ Upon Written Request to Withdraw
- ☐ Lifetime Authorization
- ☐ Upon Discontinuation of Treatment
- ☐ Upon Termination of Coverage
- ☐ On Specific Date: _____

I have reviewed and understand the content of this authorization. By signing this form, I confirm that it accurately reflects my wishes.

Patient Signature or Authorized Representative *:

Print Name: Authorization Date:

*If signed by a Legal Representative/Medicare Authorized Representative, describe your authority to act for the member. Attach appropriate documentation verifying legal authority (e.g., a copy of the power of attorney form related to healthcare authority).

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AUTHORIZATION TO PERMIT DISCLOSURE OF HEALTH INFORMATION

Your Rights with Respect to This Authorization:

Right to Inspect or Copy the Health Information to Be Used or Disclosed — I understand I have the right to inspect or copy the health information I have authorized to be used or disclosed through this authorization form. I may arrange to inspect my health information or obtain copies of my health information by contacting Lumicera.

Right to Receive Copy of This Authorization — I understand that if I agree to sign this authorization, which I am not required to do, I must be provided with a signed copy of this form.

Right to Refuse to Sign This Authorization — I understand that I am under no obligation to sign this form and that the person(s) and/or organization(s) listed above who I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization.

Right to Withdraw This Authorization — I understand that written notification is necessary to cancel this authorization. To obtain information on how to withdraw my authorization or to receive a copy of my withdrawal, I may contact Lumicera. I am aware that my withdrawal will not be effective until received by Lumicera and will not be effective regarding the uses and/or disclosures of my health information already made to the person(s) and or organization(s) listed above in reference to this authorization.

I understand that if the person(s) and/or organization(s) listed above are not health care providers, health plans, or health care clearinghouses required to follow federal privacy standards, the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and my health information may be re-disclosed without obtaining my authorization.

Please fax or mail completed authorization to:

Lumicera Health Services
310 Integrity Drive
Madison, WI 53717
Fax: 608-310-1861