# Los Angeles Police Relief Association, Inc. Health Plan

The Los Angeles Police Relief Association, Inc. Health Plan(s) (Collectively, the "Plan") will not use or disclose your "protected health information" as defined under HIPAA without your Authorization except as described in the Los Angeles Police Relief Association, Inc. Health Plan Notice of Privacy Practices, as modified by LAPRA from time to time .. If you want LAPRA, on behalf of the Health Plan, to use or disclose your protected health information in a way that LAPRA has determined willrequire your Authorization, complete this Authorization form and submit it as instructed below. This Authorization is not valid without your (or your Personal Representative's) dated signature.

Requestor's name:___________________________________________ Requestor's birthdate:_______________
(Individual for whom information is requested)

Personal Representative's name:________________________________ Relationship to Requestor:____________
(if form is completed by the Participant's Personal Representative, e.g. parent or other legal guardian or person with power of attorney) (if completed by Personal Representative)

Is the Requestor covered under a Health Plan as a dependent? ☐ **Yes** ☐ **No**

Member's name:________________________________ Member's Social Security # :________________________

I authorize LAPRA, on behalf of the following Health Plan, to use or disclose my protected health information in accordance with this Authorization (select all that apply to this Authorization):

| | |
|---|---|
| ☐ Medical (Anthem or Kaiser) | ☐ Vision |
| ☐ Anthem Blue Cross Dental | |

I authorize LAPRA, on behalf of the above-selected Health Plan, to use or disclose my following protected health information in accordance with this Authorization:

All of my protected health information from________________________________through___________________.
(start date) (end date)

All of my protected health information relating to my treatment for _______________________________________
(specific diagnosis or treatment)

_________________________________ from_______________________through________________________.
(start date) (end date)

All of my protected health information relating to my treatments provided by _______________________________
(doctor/health care provider's name)

_________________________________ from____________________________through___________________.
start date end date

Other (be as specific as possible) ________________________________________________________________

______________________________________________________________________________________________

I authorize LAPRA, on behalf of the above-selected Health Plan, to use or disclose my protected health information for the following purposes. *Check one or more boxes, as applicable:*

☐ At my request.

☐ For use by my attorney.

☐ For use by the Los Angeles Police Department or representative of the LAPD.

☐ For use by the Los Angeles Police Protective League or representative of the League.

☐ For use by LAPRA in connection with my ☐ Life Insurance Benefits
☐ Disability Benefits
☐ Emergency Relief
☐Off-payroll Extension

☐ For use by LAPRA for any other Association or benefit administered by LAPRA - name:____________________.

☐ Other:

______________________________________________

______________________________________________

Please provide the name and contact information for each person or entity to whom the above protected health information may be disclosed, if applicable. Please note – once your protected health information is disclosed to these persons or entities, LAPRA cannot prevent the redisclosure of your information by such persons or entities.

| | |
|---|---|
| Name of Person/Entity | Name of Person/Entity |
| Street | Street |
| City / State / Zip Code | City / State / Zip Code |

This Authorization is effective until__________________[expiration date or event relating to you personally], otherwise, your Authorization will remain in effect for one year or until revoked by you in writing, if earlier. You may revoke this Authorization at any time by writing to the Privacy Officer at the address below. Revocation forms are available upon request from the Privacy Officer.

If you revoke your Authorization, after receiving and processing that Revocation LAPRA will no longer disclose your protected health information except as described in the Los Angeles Police Relief Association, Inc. Health Plan Notice of Privacy Practices or as permitted under your remaining Authorizations, if any.

***Please read and sign the following statement:***

Send this completed Authorization form to:

**ATTN: Privacy Officer**
**Los Angeles Police Relief Association, Inc.**
**600 N. Grand Avenue Los**
**Angeles, California 90012**
**Fax: (213) 674-3715**

If you have questions about this Authorization form, contact LAPRA at (213) 674-3701 or (888) 252-7721.

***For internal use only:***
Date received:______________________ Date revoked:______________________