level2®

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Level2 uses this form to get your permission to disclose your personal health information, which is known as Protected Health Information (PHI) under the law. By completing and signing this form, you agree that Level2 may disclose information to the person or organization you designate below. An * indicates required information.

1: MEMBER INFORMATION
(PLEASE PROVIDE CURRENT INFORMATION)

Last Name*:	**First Name***:	**MI:**
Mailing Street Address*:		**Apt. #**:
City*:	**State***:	**Zip***:
Date of Birth (mm/dd/yyyy)*:	**Phone Number with Area Code***:	
Member ID Number:		

2: DESIGNATED PERSON OR ORGANIZATION INFORMATION

I authorize Level2 Medical Services, P.A. and the affiliated Level2 telehealth physician practices[1] (collectively, "Level2") to disclose the PHI indicated below (section 3) to the person or organization named below. I understand that my health information disclosed based on this Authorization may be subject to redisclosure by the recipient. If the recipient is not a health plan or provider, the information may no longer be protected by federal privacy regulations.

Name (First and Last)*:		
Mailing Street Address*:		**Apt. #**:
City*:	**State***:	**Zip***:
Phone Number*:		

[1] The Level2 telehealth physician practices include: Level2 Medical Services, P.A. (DE); Level 2 Medical Services, P.C. (AK); Level 2 Medical Services P.C. (CA); Level2 Medical Services, P.A. (NJ); Level 2 Medical Services, P.C. (UT); and any other physician practice that now or in the future becomes an affiliated Level2 telehealth physician practice.

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3: DESCRIPTION AND PURPOSE OF THIS AUTHORIZATION

Purpose*: ☐ **At my request** ☐ **Other (please describe):**

Information Covered by this Authorization*:

☐ I am authorizing the disclosure of all my PHI, including my health information. This may include any PHI maintained, created, or received at Level2 during your enrollment in Level2, mental health, HIV/AIDS, psychotherapy, reproductive, communicable disease, health care program information and substance abuse disorder records (if any).

☐ I wish to limit the disclosure of my PHI (please describe):

4: EXPIRATION

Date or event (ex. Upon my Level2 termination) **on which this authorization will expire** (if none listed, this authorization will expire one (1) year from the date of my signature below):

Note: For those residing in the states below, the expiration date or event cannot exceed:

12 months: MD, MN

30 months: ME, MT

You may revoke this Authorization at any time by submitting a written request to Level2 at the address below. Your revocation will not be effective to the extent that your Health information has already been released in reliance upon this Authorization.

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4: SIGNATURE*

I have read and understand the above information. I understand signing this Authorization is voluntary and Level2 will not deny treatment, payment, enrollment, or eligibility for health benefits if I do not sign this Authorization. My signature authorizes the disclosure of the information described above.

A. Member

Signature: **Date:**

Or,

B. Authorized person designated by Personal Representative who is legally appointed:

I acknowledge that by signing this form I have the legal authority to act on behalf of the member or patient and will attach copies of the appropriate documentation verifying my legal authority to this request. This can include a power of attorney or a court order.

Personal Representative's Signature: **Date:**

Personal Representative's Printed Name:

5: RETURN THE COMPLETED FORM

Mail:

Level2 Medical Services, P.A.
ATTN: Medical Records
11000 Optum Circle, MN103-0300
Eden Prairie, MN 55344

OR

Email:

Level2MedicalRecords@mylevel2.com

PLEASE KEEP A COPY OF THIS DOCUMENT FOR YOUR RECORDS.

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