LANCASTER GENERAL HEALTH
GROUP HEALTH PLAN
Authorization for Use or Disclosure of Protected Health Information

I hereby authorize the use or disclosure by a Group Health Plan sponsored by Lancaster General Health (the Plan) of my individually identifiable health information as described below. I understand that this authorization is voluntary.

_____
Plan Participant Name (please print)

_____
Address

_____ _____
Employee Name (if different from participant) Employee Number

Person(s)/Organization(s) authorized to receive health information:

_____
_____
_____

Specific description of health information authorized for release (include date(s) of service if applicable):

_____
_____
_____
_____
_____

1. I understand that this authorization will expire on (date or expiration event):

   _____

2. I understand that I may revoke this authorization at any time by notifying the Plan in writing at the address shown below.

3. I understand that the information that will be disclosed pursuant to this authorization may be further disclosed by the person who is authorized to receive it.

_____ _____
Plan Participant/Employee/or Representative Signature Date

NOTE: If someone other than the employee signs, please state his/her relationship to the employee, and explain why the employee did not sign.

_____
_____

After completing this form, please submit your request to the HIPAA Privacy Official:

Lancaster General Health
Human Resources
555 North Duke Street
P.O. Box 3555
Lancaster, PA 17604-3555

12/8/16