The following form applies solely to TELUS Health's legacy LifeWorks employees, business and the services provided through its associated legal entities.

HIPAA Release Authorization Form

Authorization for Use or Disclosure of Protected Health Information (Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

Please complete all sections of this HIPAA authorization form. If any sections are left blank, this form will be invalid and it will not be possible for your health information to be shared as requested.

1. Authorization

I authorize TELUS Health to use and/or disclose the *protected health information* described below to _____ (person or organization to receive the information).

I understand that the person(s)/organization(s) listed above may not be covered by state/federal rules governing privacy and security of data and may be permitted to further share the information that is provided to them.

2. Reason for Release

Please identify the reason(s) why this information is being shared. If you are initiating the request for sharing information and do not wish to list the reasons for sharing, simply write 'at my request':

_____

_____

3. Effective Period

This authorization for release of information covers the period of healthcare from:

a. □ _____ to _____.

OR

b. □ all past, present, and future periods.

4. Extent of Authorization

a. □ I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).

OR

b. □ I authorize the release of my complete health record with the exception of the following information:

- □ Mental health records;
- □ Communicable diseases (including HIV and AIDS);
- □ Alcohol/drug abuse treatment;
- □ Other (please specify): _____

5. This information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

6. This authorization shall be in force and effect until _____ (date or event), at which time this authorization expires.

7. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

8. I understand that my treatment, payment, enrollment, or eligibility for benefits or services will not be conditioned on whether I sign this authorization.

9. Signature

Signature of subject (or personal representative): _____

Printed name of the person completing this form: _____

Date: _____

If this form is being completed/signed by a person acting on the subject's behalf, such as a parent or legal guardian of a minor, or health care agent, please describe their legal authority:

_____

_____