HIPAA Authorization
For
Release of Protected Health Information

LOCKHEED MARTIN

I hereby authorize the Lockheed Martin Corporation Health Plans and their health care vendors and third-party administrators (collectively, "Health Plan") and their respective agents and subcontractors, to disclose confidential information about the member identified below.

I UNDERSTAND THAT THIS AUTHORIZATION IS VOLUNTARY.

Please Print All Responses

If you do not fill out both sides of this form completely, the Health Plan may be unable to process your request. Incomplete authorization requests will be returned to you.

1. Member Information

Last Name		First Name		Middle Initial
Member I.D. Number	Social Security Number	Birthdate (MM/DD/YY)	Daytime Telephone Number (include area code)	
Street Address			City, State and Zip Code	

Section 2: Employee information (if different than Member)

Last Name		First Name		Middle Initial
I.D. Number on Member Card	Social Security Number	Birthdate (MM/DD/YY)	Daytime Telephone Number (include area code)	
Street Address			City, State and Zip Code	

2. I authorize the individual(s) or company(ies) identified below to receive confidential health information pertaining to the Member named above.

Individual or company authorized to receive confidential information	Daytime Telephone Number (include area code)
Street Address	City, State and Zip Code
Individual or company authorized to receive confidential information	Daytime Telephone Number (include area code)
Street Address	City, State and Zip Code
Individual or company authorized to receive confidential information	Daytime Telephone Number (include area code)
Street Address	City, State and Zip Code

3. Purpose(s) for this Authorization

This authorization is for the Health Plan:

- ❑ To respond to all requests for confidential information made by the individual(s) or company (ies) named in Section 2 above
- ❑ To respond to requests for only the following specific information (for example, disclosures about claims submitted by a specific provider or regarding a particular claim number):

_____

_____

_____

_____

If this Authorization is limited to information in effect for a specific period of time, please indicate: _____ through _____
mm/dd/yy *mm/dd/yy*

4. Type of coverage to which this Authorization applies (check all that apply):

☐ Health (specify applicable health benefits below): ☐ Long Term Care ☐ EAP

- ☐ Medical
- ☐ Dental
- ☐ Vision
- ☐ Pharmacy
- ☐ Mental Health
- ☐ Health Care Spending Account
- ☐ Other (please specify): _____

5. Description of the information to be released or disclosed (check all that are appropriate):

- ❑ Application or enrollment information
- ❑ Claim records (Specify claim number, if available): _____
- ❑ Claim status
- ❑ Patient management records
- ❑ Other (please specify): _____

6. IMPORTANT: Your signature below means that you understand and agree to the following:

- I understand that this Authorization applies to the Health Plans sponsored by Lockheed Martin Corporation and that I may authorize a specific health care vendor or third-party administrator providing services to the Health Plan to release my protected health information.
- The protected health information provided under this Authorization may include diagnosis and treatment information, including information pertaining to chronic diseases, behavioral health conditions, alcohol or substance abuse, communicable disease, including HIV/AIDS, and/or genetic marker information. These records will be included in the information that will be made available to the individual(s) or company(ies) identified in Section 2 above.
- Information disclosed under this Authorization may be redisclosed by the recipient and will no longer be protected by HIPAA.
- I understand that I may be charged a reasonable fee (except where prohibited by law) to defray copying and mailing costs for requests of copies of claims or other personal information from the individual or company that I have authorized to receive this information.
- Your ability to enroll in the Health Plan, your eligibility for benefits, and payment for services will not be affected if you do not sign this form. (However, without your signature, your request to release the information described above to a third party will not be honored.)
- You may receive a copy of this form if you ask for it by writing to the address listed at the bottom of this Authorization.
- This Authorization will expire ____days from the date you sign this Authorization. If you sign this form, you may revoke the Authorization at any time by notifying the [Health Plan/Health Care Vendor] in writing at the address below. Revoking this Authorization will not have any impact on actions that the Health Plan took in reliance on the Authorization before we received the notification.

7. Signature of Member or Member's Legal Representative

Signature of Member or Member's Legal Representative, or Member's Parent (if Member is an unemancipated minor child) Date

_____ _____

Print Name Date

_____ _____

If the person signing this Authorization is not the Member, describe relationship to the Member.

- ❑ Natural or adoptive parent of unemancipated minor child
- ❑ Legal representative (i.e., someone with legal authority to act on the Member's behalf)

If this Authorization is being signed by Member's legal representative (other than a parent of an unemancipated minor child), you must furnish a copy of the health care power of attorney, or other relevant document authorizing you to act on the Member's behalf.

Return this completed form to:

Lockheed Martin Corporation
6801 Rockledge Drive
CCT – 115
Bethesda, MD 20817