



# AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Name of Member: \_\_\_\_\_  
Member's ID: \_\_\_\_\_ Member's Date of Birth: \_\_\_\_\_  
Member's Street Address: \_\_\_\_\_  
City, State & Zip: \_\_\_\_\_  
Phone Number: \_\_\_\_\_

Name of Requestor: \_\_\_\_\_  
Relationship to Member:  
 Self  
 Spouse  
 Parent  
 Legal Guardian (Attach Legal Documentation)  
 Other: \_\_\_\_\_ (Attach Legal Documentation)

I authorize LDI to release the following information for the Member listed above:

Medical Expense Statement  
From \_\_\_\_\_ (mm/dd/yyyy) To \_\_\_\_\_ (mm/dd/yyyy)

Prescription History  
From \_\_\_\_\_ (mm/dd/yyyy) To \_\_\_\_\_ (mm/dd/yyyy)

Other Protected Health Information: \_\_\_\_\_  
From \_\_\_\_\_ (mm/dd/yyyy) To \_\_\_\_\_ (mm/dd/yyyy)

This information should be released to:

Member listed above ( and / or )

Name: \_\_\_\_\_  
Organization: \_\_\_\_\_  
Street Address: \_\_\_\_\_  
City, State & Zip: \_\_\_\_\_

I understand that this Authorization is valid for 90 days, and that I have the right to revoke this Authorization at any time to prevent future disclosures. The revocation must be in writing. LDI will not put conditions on treatment, payment, enrollment or eligibility based on the status of this Authorization. The information disclosed pursuant to the authorization will be subject to disclosure by the recipient and will no longer be protected by LDI.

I certify that the information above is true and correct.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Print Name: \_\_\_\_\_

Please Return to: LDI integrated pharmacy services, 680 Craig Road, Suite 200, Creve Coeur, MO 63141

Internal Use Only:  
Date Request Received: \_\_\_\_\_ Date Request Delivered: \_\_\_\_\_  
Request Received By: \_\_\_\_\_ Request Delivered By: \_\_\_\_\_