AUTHORIZATION FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Name: _____

Medicare Claim Number: _____

I herby authorize the use and/or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I also understand that if the person or organization authorized to receive the information is not a health plan or health care provider, the released information may be redisclosed and may no longer be protected by the federal privacy regulations.

1. Person(s) or organization authorized to disclose the health information:_____
_____

2. Person(s) or organization authorized to receive the health information_____
_____

3. Description of health information that may be used/disclosed_____
_____

4. Purpose for which the health information will be used/disclosed (Note: Not required if disclosure is requested by the individual):_____
_____

5. I understand that the person or organization that I am authorizing to use/disclose the information may receive compensation in exchange for using or disclosing the health information described above.

6. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to enroll in a health plan, obtain health care treatment or payment or my eligibility for benefits. (Note: Not required if disclosure is requested by the individual.)

7. I understand that I may revoke this authorization at any time by providing written notice to the same persons or entities named in Paragraph 1 above. I understand that my revocation will not affect any actions already taken in reliance on this authorization.

8. I understand I may inspect or copy any information to be used or disclosed under this authorization.

9. Unless otherwise revoked in writing, this authorization will expire in six (6) months from the date signed below.

_____ _____

Signature of Individual (or Legal Representative) Date