RetireeFirst Protected Health Information Release Form

HIPAA COMPLIANT AUTHORIZATION FOR THE RELEASE OF PATIENT INFORMATION PURSUANT TO 45 CFR 164.508

ALL ITEMS ON THIS AUTHORIZATION MUST BE COMPLETED IN FULL OR THE REQUEST WILL NOT BE HONORED

RE: Patient Name: _____

Date of Birth: _____ Social Security Number: _____

I, _____, hereby authorize and request the disclosure of the following protected health information ("PHI") pursuant to the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA"), as described below to

Name of Party to Receive Information: _____

Address of Party to Receive Information: _____

Phone No. of Party to Receive Information: _____

E-mail of Party to Receive Information: _____

I understand that this authorization is voluntary. No individual has coerced me into signing this authorization, and I am providing this authorization under my own free will.

Requested Information to be Released:

_____

_____

_____.

PLEASE REVIEW THE FOLLOWING TWO PROVISIONS AND PLACE AN "X" IN THE BOX IF YOU AGREE TO THE POTENTIAL RELEASE OR DISCLOSURE OF THE INFORMATION SET FORTH

[ ] I understand that the information to be released or disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). I authorize the release or disclosure of this information.

[ ] I understand that the information to be released or disclosed may include information relating to alcohol or substance abuse. I authorize the release or disclosure of this information.

I understand the following:

a. I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization. To revoke authorization, I may submit a written revocation to the HIPAA Privacy Official at Retiree First.

b. The information released in response to this authorization may be re-disclosed to other parties and may no longer be protected by federal privacy laws. I understand that the party making the use and/or disclosure is not responsible for ensuring that any recipient of my PHI will further use and/or disclose the information for the purposes listed below.

c. My treatment or payment for my treatment cannot be conditioned on the signing of this authorization.

Any facsimile, copy, or photocopy of the authorization shall authorize you to release the records requested herein.

This authorization shall be in force and in effect until the end of all insurance coverage(s) with RetireeFirst at which time this authorization expires. (See 45CFR § 164.508(c)(1)(vi)).

By signing below, I acknowledge and affirm the statements in this authorization form and acknowledge that I have received a copy of the signed form.

_____ _____

Signature of Patient or Legally Authorized Representative Date

_____ _____

Name and Relationship of Legally Authorized Representative of Patient Date