insuranceTPA.com℠
ADMINISTRATORS

## Authorization for Use or Disclosure of Protected Health Information

*** Required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA)**

### 1. Patient Information

Patient Name: _____

Patient Address: _____

Patient DOB: _____

Plan ID#: _____

### 2. Authorization

I authorize **InsuranceTPA.com Administrators** to use and disclose the protected health information described below to the following individual(s):

Name: _____

Telephone #: _____

Name: _____

Telephone #: _____

### 3. Purpose

Please check all that apply:

❑ Legal Investigation/Action ❑ Personal/Relationship:_____ ❑ Other: _____

### 4. Dates of Information to be Disclosed

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

❑ _____ to _____

❑ All past, present, and future periods.

### 5. Information to be Disclosed

I authorize the following information to be disclosed (Must select one of the following):

❑ All of my protected health and medical history; including information and/or records relating to mental healthcare, communicable disease, HIV or AIDS, and treatment of alcohol or drug abuse.

❑ All of my protected health and medical history information, with the exception of the following information:

- ❑ Mental health
- ❑ Communicable diseases (including HIV and AIDS)
- ❑ Alcohol/Drug abuse treatment
- ❑ Other (please specify): _____.

**This form must be completed in its entirety in order to be considered valid.**

## 6. Expiration

This authorization shall be in force and effective until _____ (Date), at which time this authorization expires.

**NOTE: If left blank, this authorization will expire in one (1) year from the date signed.**

## 7. Your Rights with Respect to this Authorization

- I understand that this medical 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.
- I understand that I have a right to revoke this authorization at any time. However, such revocation must be made in writing and will not apply to any information already released under separate cover and under the terms of this authorization.
- I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.
- I understand that my treatment, payment, enrollment or eligibility for benefits will not be conditioned on whether I sign this authorization.

**InsuranceTPA.com Administrators is required by law to maintain the privacy of your health information. We are also required to provide you with this notice of our legal duties and our privacy practices with respect to your health information.**

_____

Signature of Patient or Legal Representative Date

_____

Print Name and Relationship of Legal Representative to Patient (If applicable)

**This form must be completed in its entirety in order to be considered valid.**