AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION - HIPAA AND HITECH COMPLIANT

RELEASOR/PATIENT'S NAME: ____
ADDRESS: ____
TELEPHONE NO.: ____
NAME OF EMPLOYER: ____
GROUP HEALTH PLAN ID No: ____

I understand that my protected health information is individually identifiable health information, including demographic information, collected from me or created or received by a health care provider, a health plan, my employer, or a health care clearinghouse and that relates to: (i) my past, present, or future physical or mental health or condition; (ii) the provision of health care to me; or (iii) the past, present, or future payment for the provision of health care to me.

☐ I authorize HealthComp to disclose my protected health information to the following individual, organization, or class of persons (*e.g.,* group of individuals within the organization):

____

☐ I authorize HealthComp's employees and agents to speak to and discuss my medical conditions—including, but not limited to, past treatments, diagnosis, medical conditions, or future treatments—with the following designated persons:

____

The protected health information that may be used and disclosed is as follows *[Describe in as much detail as possible the protected health information that you wish to be used or disclosed. For example, types of claims, dates of service, or types of service.]*:

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____

My protected health information will be limited to disclosure for the following purpose(s): *[Describe any limitations to the reasons the information is allowed to be discussed. If this area is left blank, you authorize HealthComp to disclose the personal health information to the designated persons without limitation.]*

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I understand that if my protected health information is to be received by individuals or organizations that are not health care providers, health care clearinghouses, or health plans covered by federal privacy regulations, my protected health information described above may be re-disclosed and no longer protected by federal privacy regulations.

I understand that I may revoke this authorization at any time by sending a written notification to HealthComp Administrator's Privacy Official at P.O. Box 45018, Fresno, CA 93718-5018, and this revocation will be effective for future uses and disclosures of protected health information. However, I further understand that this revocation will not be effective for information that HealthComp Administrators already has used or disclosed, relying on this authorization. This authorization expires ______________, or until revoked by me.

SIGNATURE: ______________________________________**DATE:** ____________________________
If this request is by a personal representative on behalf of the individual, complete the following:
PERSONAL REPRESENTATIVE'S NAME: ____
DESCRIPTION OF AUTHORITY: ____