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

Information / blanks in BLUE ink are mandatory.

TO: (ER / Hospitalist Physicians Group):_____

RE: Patient Name:_____

Other Names / Aliases:_____

Date of Birth:_____ Social Security Number: XXX-XX-_____

I expressly request that the designated record custodian of Mediserv, Ltd. and all covered entities under HIPAA (identified above) disclose full and complete protected medical information including the following:

All billing records including all statements, insurance claim forms, itemized bills, and records of billing to third party payers, and payment or denial of benefits for the period below:

FROM (1st Date of Treatment):_____

To (Final Date of Treatment):_____

I understand the information to be released or disclosed may include information relating to sexually transmitted diseases, mental illness, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), and alcohol and drug abuse. I authorize the release or disclosure of this type of information.

This protected health information (PHI) is disclosed for the following purpose(s):

_____

This authorization is given in compliance with the federal consent requirements for release of alcohol or substance abuse records of 42 CFR 23.31, the restrictions of which have been specifically considered and expressly waived.

The undersigned, being either the patient or the duly authorized representative of the patient identified above, hereby authorizes Mediserv, Ltd. to release the above-identified records to:

Name of Representative:_____

Representative Capacity:_____
(e.g., attorney, records requestor, agent, etc.)

Mailing Address:_____

I understand the following: [See CFR 164.508(c)(2)(i-iii)}

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.**
b. **The information released in response to this authorization may be re-disclosed by the recipient and no longer protected by the federal privacy regulations.**
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 effect until two years from date of execution at which time this authorization expires. [See 45 CFR 164.508(c)(1)(VI)]

Signature:_____ Date:_____
Patient or Legally Authorized Representative

_____
Printed Name of Patient or Legally Authorized Representative

_____
Relationship to Patient / Description of Signer's Authority to Act for Patient