HIPAA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information

I, _____ Date of Birth _____ authorize _____(healthcare provider) to use and disclose the protected health information described below to MEDgomics.

**1. This authorization for release of information covers the period of healthcare. For all past, present, and future periods.

** 2. 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.

** 3. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

** 4. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

** 5. 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.

_____ _____

Signature of patient or personal representative Printed name and Relationship to patient

_____

Date