Authorization for Health Information Disclosure

This form is compliant with the HIPAA Privacy Rule

Patient Information

(please print)

Patient Name: ______________________ Date of Birth: ____________

Street Address: ______________________

City/State/Zip: ______________________

I hereby authorize: ______________________

Name of Physician's office/medical practice disclosing the information

Requester/Recipient Information

(please complete ALL parts of this section)

Please disclose the following protected health information to: Hoosier Services Inc

Street Address: 18032 Lemon Dr Ste C-618

City/State/Zip: Yorba Linda, CA 92886

Please indicate the information or types of information to be disclosed: all medical records notes, labs, x/r reports, diagnostic testing

Specify dates (or date range) if applicable: ______________________

This request is for the purpose of: Life Insurance

I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing and addressed to the privacy officer of the above named facility authorized to make this disclosure. I understand that the revocation does not apply to information that has already been released in response to this authorization.
Unless otherwise revoked, this authorization will expire in six months or on the following date: ____________

I understand that any disclosure of information may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. I understand that I need not sign this authorization to ensure treatment. I understand that I may inspect and/or copy the information to be disclosed. I understand that authorizing this disclosure is voluntary. I understand that if I have any questions about disclosure of my health information, I may contact the privacy officer at the facility listed above that is authorized to disclose this information and request a copy of this authorization.

I understand that my health record may include information pertaining to the treatment of drug and alcohol abuse, mental illness, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), sexually transmitted diseases, tuberculosis, Hepatitis C, or genetic testing.

IF YOU DO NOT WISH THIS INFORMATION TO BE RELEASED, PLEASE INITIAL; DO NOT RELEASE ______

______________________ Date: ____________

Signature of Patient or Authorized Representative (if applicable in which case proof is required)

____

Description of Representative's Authority (witness signature required)

____

Signature of Witness (when patient is unable to sign only)

FAILURE TO COMPLETE <u>ALL</u> PORTIONS OF THIS FORM WILL RESULT IN DELAY OF YOUR REQUEST