PATIENT AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

USE AND DISCLOSURE OF HEALTH INFORMATION

I hereby authorize the use or disclosure of my health information as follows:

Name of Patient:_____ Date of Patient's Birth:_____

Address of Patient:_____

1. Class of persons/organizations authorized to *disclose* my protected health information: All of my physicians, nurses, skilled nursing facilities, assisted living centers, hospitals, clinics, outpatient facilities, pharmacies, physical therapists, mental health therapists and any and all other healthcare providers of mine.

2. Name and address of persons/organizations authorized to *receive* the information: Liquid Healthcare USA, Inc. of 200 Bellevue Parkway, Suite 170, Bellevue Corporate Park Center, Wilmington, Delaware 19809

3. Purpose of requested use or disclosure: At the request of the patient, for purposes of _____.

4. This Authorization applies to the following information: All health and billing information pertaining to any medical history, mental or physical condition and treatment received (including mental health records protected by state law, genetic test results, drug and/or alcohol abuse records and/or HIV test results) other than psychotherapy notes.[1] Except:_____

EXPIRATION

This Authorization expires [*insert date*]: January 1, 2060

YOUR RIGHTS

I may refuse to sign this Authorization and neither treatment, payment, enrollment or eligibility for benefits will be conditioned on my providing or refusing to provide this Authorization. I understand that if I do not sign this form, my healthcare providers may not disclose my medical information to my family members.

I may revoke this Authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to each of my healthcare providers to whom I have given this Authorization. I

understand that my revocation will be effective upon receipt, but will not be effective to the extent that my healthcare provider or the recipient or others have acted in reliance upon this Authorization.

I acknowledge that I have received a copy of this authorization. I understand that I may inspect or obtain a copy of the health information used or disclosed subject to this authorization.

SIGNATURE

Date _____ Time _____ AM/PM

Signature:_____, as the (*check one*):

☐ Patient ☐ Patient's legally authorized representative (give relationship and furnish copies of any appointment papers):_____

Witness:_____

If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may be redisclosed and may no longer be protected.

[1] Release of psychotherapy notes requires a separate authorization.