HIPAA COMPLIANT AUTHORIZATION

TO DISCLOSE PROTECTED HEALTH INFORMATION

PATIENT NAME: _____

SOCIAL SECURITY # _____ DATE OF BIRTH: _____

1. Records and information obtained will be disclosed to: _____
2. The following individual or medical facility is authorized to make the disclosure:

   _____

   _____

   _____

   Phone _____ Fax _____

3. Medical Records are to be disclosed for the period of _____.
4. I understand that the information in my health records may include information relating to sexually transmitted disease, communicable or non-communicable disease, Acquired Immunodeficiency Syndrome (AIDS), or Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol or drug abuse.
5. This information may be disclosed and exchanged between the insurance company named above and Harry J. Cangany, Jr., CLU, for the purpose of insurance.
6. I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing to Harry J. Cangany, Jr., CLU. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____. If I fail to specify an expiration date, event or condition, this authorization will expire in 6 months.
7. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. Statement of treatment, payment, enrollment or eligibility for benefits cannot be conditioned upon obtaining authorization. I understand I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand any disclosure or information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

If I have any questions about disclosure of my health information, I can contact the Entity listed in item #2 of this form.

SIGNATURE _____ DATE: _____

If signed by Legal Representative, relationship to Patient _____

A copy of this form may be valid as the original unless specified otherwise.

Email: staff@cangany.com