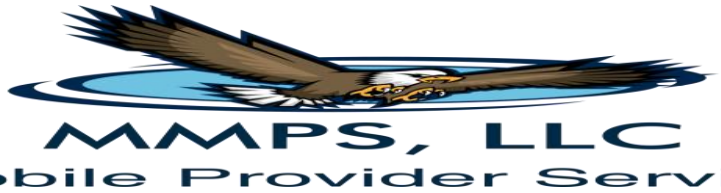
HIPAA 

Privacy Authorization Form **Authorization for Use or Disclosure of Protected Health Information (Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164) **

#1.

I authorize **Muberrys Mobile Provider Services, LLC** (healthcare provider) to use and disclose the protected health information described below to _____(individual seeking the information).

#2.

Effective Period

This authorization for release of information covers the period of healthcare from:

a. _____ to _____.

OR

b. □ all past, present, and future periods.

#3.

Extent of Authorization

a. I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV, or AIDS, and treatment of alcohol or drug abuse).

OR

b. I authorize the release of my complete health record with the exception of the following information __Mental health records, ___Communicable diseases (including HIV and AIDS) ___Alcohol/drug abuse treatment
c. Other (please specify): _____

#4.

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.

#5.

This authorization shall be in force and effect until _____ (date or event), at which time this authorization expires.

#6.

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.

#7.

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

#8.

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 of patient or personal representative and his or her relationship to patient

_____

Date