

HIPAA Release of information
AUTHORIZATION FORM

I, child's name hereby authorize doctor you ask or obtain
medical info and its affiliates, its employees and agents (collectively dr's group), to release to HQMC / BUMED [Insert full name of person/organization] my personal health information maintained by dr's group (e.g., information relating to the diagnosis, treatment, claims payment, and health care services provided or to be provided to me and which identifies my name, address, social security number, Member ID number) except the following information about me:

any info you don't want disclosed

[DESCRIBE INFORMATION NOT TO BE DISCLOSED, IF ANY] for the purpose of helping me to resolve claims and health benefit coverage issues. I understand that any personal health information or other information released to the person or organization identified above may be subject to re-disclosure by such person/organization and may no longer be protected by applicable federal and state privacy laws.

This authorization is valid from the date of my/my representative's signature below and shall expire the earlier of date or N/A [INSERT DATE/EVENT UPON WHICH THIS AUTHORIZATION EXPIRES] or the date my coverage ends with date / N/A / or group of doctors

I understand that I have a right to revoke this authorization by providing written notice to HQMC / BUMED. However, this authorization may not be revoked if HQMC / BUMED, it's employees or agents have taken action on this authorization prior to receiving my written notice. I also understand that I have a right to have a copy of this authorization.

I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment or payment for or coverage of services.

Name of Member: child's name
Signature of Member: child signs if capable
Date: _____

* If applicable, Legal Representatives sign below:
By signing this form, I represent that I am the legal representative of the Member identified above and will provide written proof (e.g., Power of Attorney, living will, guardianship papers, etc.) that I am legally authorized to act on the Member's behalf with respect to this authorization form.

Name of Legal Representative: conservator or guardian
Signature of Legal Representative: " "
Date: _____

Name of Witness: _____
Signature of Witness: _____