

HIPAA Compliant Authorization for Release of Protected Health Information

I hereby authorize the protected health information for _____
(Patient Last Name) (First Name) (Middle)

("Individual") to be released as specified in this HIPAA compliant Authorization.

1. Description of Information To Be Disclosed: For dates of service: _____

I authorize the release of any and all records and information pertaining to the Individual's medical care, treatment, and physical and psychological condition including, but not limited to:

- Accreditation Forms Admission Advance Directives Ambulance Anesthesia
- Autopsy Billing Records Cath Films Catheterization/Angiography Claims History
- Consent Forms Consultations/Evaluations Correspondence CPR/Code Sheets CT Scan Reports
- CT Scans Delivery Diagnostic Testing Discharge/Transfer Summary Echocardiogram
- Echocardiogram Tapes Education Records EKG Emergency Room Fetal Monitor Strips
- Graphic/Flow Charts History/Physical Implant Related Records Labor Laboratory
- Medication Records MRI Reports MRI Scans Nurse's Notes Nursery
- Nutrition Records Operative Records Pathology Report Pathology Slides Patient Care Plan
- Photographs Physical Therapy Physician Orders Physician Progress Notes Post Anesthesia
- Post-Partum Pre-Natal Procedures Psychiatry/Social Service Radiation Records
- Rehabilitation Respiratory Speech Pathology Transfusion Records Ultrasound Reports
- Ultrasounds Videos X-ray Films X-ray Reports

Complete Medical Record (includes information regarding insurance, demographics, referral documents and records from other facilities).

Other: _____

I recognize that the protected health information may include psychiatric information, drug and alcohol information and/or HIV information. _____ (Individual's/Representative's initials)

2. Entities Authorized to Disclose: I authorize any hospital, clinic or other medical facility, physician, nurse, physical or occupational therapist, chiropractor, psychiatrist, psychologist, medical practitioner, pharmacy, emergency medical service, basic life support service, advanced life support service, insurance company, the Medical Information Bureau or any other person or entity licensed to create and/or maintain protected health information for the Individual to disclose the Individual's health information as described above.

3. Information Disclosed To: I authorize the Individual's information to be disclosed to:

MediConnect.net, Inc.

10897 South Riverfront Pkwy, Suite 100

South Jordan, Utah 84095

FOR Company: United Health International ("**Agent**")

Address: 777 Bay St., Suite 2700

City, ST, Zip: Toronto, Ontario CANADA M5G 2C8

any of Agent's re-insurers, subsidiaries, other insurers to which the above-named has applied or may apply, the Bureau, other persons who perform business, professional, or underwriting tasks for Agent, or as may be otherwise allowed by law. The protected health information will be used for claim adjudication.

I authorize any third-party record retrieval agent to retrieve the protected health information as described above for use by Agent and other authorized recipients.

4. Expiration Date: This authorization expires two years after the date I sign it.

5. Right to Revoke: I understand that I have the right to revoke this authorization at any time by notifying Agent and the medical record custodian in writing. The revocation would not be effective for any actions taken in reliance upon this authorization prior to the receipt of revocation.

6. Re-disclosure: I recognize that protected health information disclosed to Agent or other authorized recipients may no longer be protected by HIPAA or other federal laws.

7. Eligibility for Benefits: Treatment, payment, enrollment in a health plan, or eligibility for health insurance benefits may not be conditioned on my signing this authorization.

8. Facsimiles: A copy or facsimile of this authorization is as valid as the original.

9. My Right to a Copy: I hereby understand that I have a right to a copy of this fully-executed authorization which I can obtain from Agent.

I have read and understood this authorization and authorize the disclosure of the protected health information as described above.

Signed: _____

Individual's SSN: _____ - _____ - _____

Date: _____

Individual's DOB: ____/____/____

(Please complete the following section if the person signing this authorization is acting as the legal representative of the above-named Individual.)

Relationship of Representative to Individual: _____

Authority of Representative to act on behalf of Individual: _____