

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION
(HIPAA Release Form)

1. In the event of a medical related emergency whereby the state and/or federal mandated emergency response teams need to be dispatched to my aid, I authorize the use and disclosure of my protected health information as defined under the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) as set forth below:
2. The following individual(s) or organization(s) is/are authorized to make disclosure of any or all of my protected health information to my HIPAA personal representative upon his/her request:
 - A. Any and all health care providers, insurers and/or third party administrators who may have possession or custody of such information. For this purpose health care providers include but are not limited to physicians, hospitals, surgical centers, physicians assistants, nurses, aides, paramedics, pharmacies, therapists and technicians.
3. The type and amount of information to be used or disclosed is as follows:
 - A. Entire record: All information of every kind relating to my health, including but not limited to medical treatment, hospitalizations, surgical procedures, prescription drugs, nursing care, diagnoses, physician's notes, etc.
 - B. alcohol, psychiatric and or drug abuse records, subject to federal regulations (42 CFR Part 2)
4. I understand that my protected health information may include information relating to sexually transmitted 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 and drug abuse.
5. 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 and present my written revocation to all health care providers with whom this authorization may have been filed. I understand such revocation will not apply to information that has already been released in response to this authorization. I understand such revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. This authorization will continue indefinitely until revoked in writing by me and will otherwise continue for two years following my death.
6. Health care providers may not condition treatment, payment, enrollment or eligibility for benefits upon the execution of this Authorization.
7. I understand that authorizing the disclosure of my protected health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand any disclosure of information carries with it the potential for re-disclosure and the information may not be protected by federal confidentiality rules.

I understand that the sole purpose of this HIPAA Release Form is so that Emergency Responders, Hospitals and Doctors may have access to my medical records in the event of a medical related emergency, and that I may not request My911, Inc. or any of its personal at any time to assist in obtaining such information for whatever purpose or reason.

By clicking the “Accept” option, you hereby accept the Release of your HIPAA information in the event of a medical related emergency.