HIPAA AUTHORIZATION TO RELEASE MEDICAL RECORDS AND INFORMATION

Name: _____

Address: _____

_____

Social Security Number: _____

Date of Birth: _____

To any physician, health care professional, dentist, health plan, hospital, clinic, laboratory, pharmacy, or other covered health care provider, any insurance company, and the Medical Information Bureau, Inc., or other health care clearinghouse that is providing or has provided or proposes to provide treatment or services to me or payment for such treatment or services, or that is seeking payment from me for treatment or services, including but not limited to Universal Credit Services, I hereby state as follows:

1. **Authorization.** I authorize you to give, disclose, and release to any one or more of my agents named in Paragraph 2 below, without restriction, all of my individually identifiable health information and medical records and all other information regarding my past, present, or possible future medical, dental, or mental health condition or treatment. This shall include but shall not be limited to all information relating to the diagnosis and treatment of any mental illness, drug or alcohol abuse, and the billing or payment for such diagnosis and treatment. This also includes the broadest possible right to discuss any such information with my agent(s) and to discuss any matters with them that could be discussed with me personally. The authority given to my agent shall supersede any prior agreement that I may have made to restrict access to or disclose my individually identifiable health information.

2. **Provide information.** The information identified in this document may be released, provided to, or discussed with any of the following persons or entities, who are my agent(s) for this purpose:

Name: _____

Company: _____

Address: _____

_____

Telephone: _____

Facsimile: _____

E-mail: _____

3. **When and how to provide information.** You are authorized to provide the information identified in this document at any time and from time to time at the request of any one or more of the individuals identified in Paragraph 2 above. It may be provided by direct in-person discussion, or by e-mail, telephone, fax, or any other type of communication. You may assume that whoever is communicating with you by telephone, e-mail, fax, or other type of communication is the person as represented by that individual.

4. **Expiration.** This authorization contains no expiration date.

5. **Authority to revoke.** I reserve the right to revoke this authorization. In order to revoke this authorization, the notification must be written, signed by me, and dated. The revocation will then become effective upon delivery to you.

6. **Redisclosure.** I understand that the information disclosed by reason of this document may be subject to redisclosure by the recipient and therefore may no longer be protected under state or federal law.

7. **Photostatic copies.** A photostatic copy of this Authorization shall be considered as effective and valid as the original.

8. **Voluntary action.** I understand that I am not required to sign this document, and I am signing this document voluntarily.

9. **Privacy waiver.** With regard to the disclosure of information authorized in this document, I waive any right of privacy that I may have under the authority of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191, that might otherwise prevent any person or entity to whom this release is delivered from providing access to my medical records or other information authorized to be released under this document, and I hold harmless from any claim of liability under such act, rule, or regulation any person or entity who provides information or access to my medical information and records under this document.

10. **Durable power.** This authorization shall not be affected by my disability. The authority of my agent shall be exercisable notwithstanding my later disability or incapacity or later uncertainty as to whether I am alive.

Dated: _____

_____
Signature

_____
Printed Name

<u>Please return completed form to:</u>

Universal Credit Services
P.O. Box 158
Hartland, MI 48353-0158
E-mail: ucs@ucscollections.com