

HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

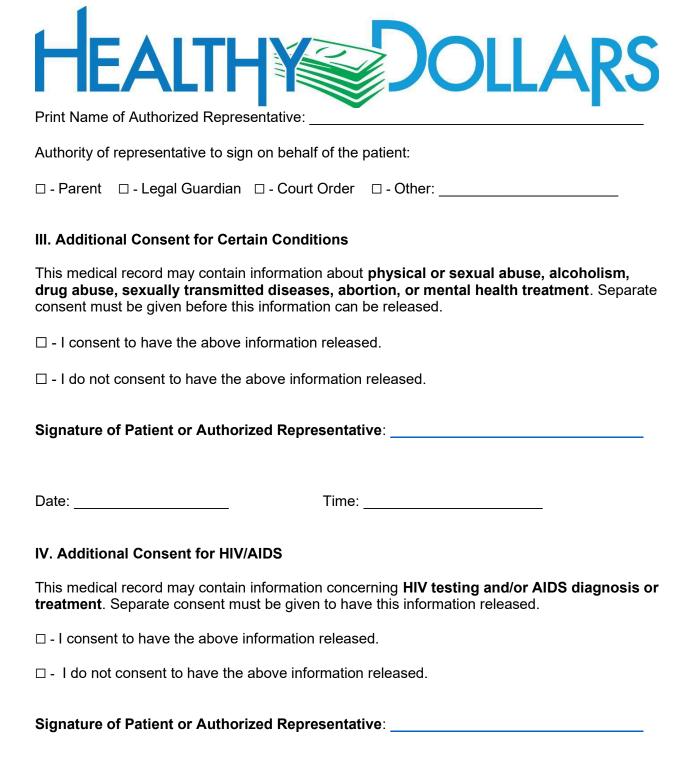
Print Name of Patient:			
Date of Birth:	Last 4 of SSN:		
Employer:			
I. My Authorization			
I authorize the following designa information to Healthy Dollars, Ir			release
To use, disclose and/or releas	e the following health in	formation: (check one)	
☐ - All of my health information of	on file with Healthy Dollars	3	
□ - My health information relating	g to the following:		
☐ - My health information coveri	ng the period from	(date) to	(date)
□ - Other:			
The above party may disclose	health information to th	e following recipient:	
Healthy Dollars, Inc. P.O. Box 8592 Essex, VT 05451 877-900-6979 Service@healthydollarsinc.com			
The purpose of this authorizat	ion is: (check all that app	oly)	
□ - At my request			
□ - Other:			





□ - To authorize the using or disclosing party to communicate with me for marketing purposes when they receive payment from a third party to do so.
□ - To authorize the using or disclosing party to sell my health information. I understand that the seller will receive compensation for my health information and will stop any future sales if I revoke this authorization.
This authorization ends: (check one)
□ - On (date)
□ - When the following event occurs:
I. My Rights
understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission. I may not be able to revoke this authorization if its purpose was to obtain insurance. In order to revoke this authorization, I must do so in writing and send it to the appropriate disclosing party.
understand that uses and disclosures already made based upon my original permission cannot be taken back.
understand that it is possible that information used or disclosed with my permission may be redisclosed by the recipient and is no longer protected by the HIPAA Privacy Standards.
understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create health information for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization.
will receive a copy of this authorization after I have signed it. A copy of this authorization is as valid as the original.
Signature of Patient:
Date:
f the patient is a minor or unable to sign, please complete the following:
□ - Patient is a minor: years of age
□ - Patient is unable to sign because:
Signature of Authorized Representative:
Data





Time: _____

