AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

A. Authorization for Use or Disclosure of Information

I hereby authorize the use and/or disclosure of my "Protected Health Information" (as defined in the Health Insurance Portability and Accountability Act of 1996, as amended (HIPAA)) as described below. I understand:

1. Information disclosed may be subject to redisclosure by the recipient and may no longer be protected by federal privacy laws, except as indicated in Section A.2 below. I understand that the party making the use and/or disclosure (as indicated below) is not responsible for ensuring that any recipient of my Protected Health Information will further use and/or disclose the information for the purposes listed below.

2. If the health information described below includes information relating to the treatment of drug and alcohol abuse, this authorization may allow the disclosure of drug and alcohol treatment information, except psychotherapy notes, if I initial the appropriate line in Section B.5 below. The recipient may not redisclose alcohol and drug treatment information without my explicit consent unless permitted to do so under applicable law.

3. This authorization is voluntary and I may refuse to sign it. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.

4. I acknowledge I have the right to revoke this authorization at any time by contacting the health care provider listed below. I understand that my revocation must be in writing. I also understand that my revocation will be valid except to the extent that the person(s) or organization(s) authorized to make the requested use and/or disclosure have taken action in reliance on the authorization before it is revoked.

B. Information to be Used and/or Disclosed and to Whom

1. Period this authorization is valid: _____[time period].

2. Name of individual whose Protected Health Information is the subject of this authorization: _____[name].

Individual's date of birth: _____[date of birth].

3. Name and address of health care provider or entity authorized to use and/or disclose the Protected Health Information:

(a) iWill Advocates/Golden Guardians Concierte

(b) _____

4. Name and address of person(s) or organization(s) authorized to receive the Protected Health Information:

iWill Advocates/Golden Guardians Concierge, _____ [person(s)/entity(ies)].

5. Specific description of Protected Health Information to be used and/or disclosed:

_____[description of medical records]

Include: _____ Alcohol/Drug Treatment Information (if initialed by individual)

6. Description of each purpose of the requested use and/or disclosure of Personal Health Information:
_____[purpose(s) description].

Signature of _____[name of individual] or his or her representative:

_____

[Date]_____

If signed by a representative:

Print name of representative: _____

Relationship of representative (including basis of authority to act as personal representative):
_____