AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Applicant Name: _____ Employee Name (if different): _____
Date of Birth: _____ Social Security Number: _____
Phone: _____ Email: _____
Address: _____ County: _____
Employer: _____ Do you have Medicare? ☐ Yes ☐ No
Diagnosis: _____

1) I authorize the use or disclosure of the above-named individual's health information as described below.
2) The following individual or organization is authorized to make the disclosure:

   _____
3) The type and amount of information to be used or disclosed is as follows:
   A true and complete copy of all medical records including, but not limited to, all emergency room records, in- patient records, out-patient records, medical reports, narratives, history and physical reports, discharge summaries, x-ray reports, x-ray and imaging study films, diagnostic test results and reports, laboratory test results and reports, medication administration records, billing records and invoices concerning treatment and/or care of said patient, operative reports, pathology reports and records, cytology reports and records, doctors' notes, nurses' notes, consultants' reports, consent forms; any attachments to the jackets containing the medical records of said Patient; a copy of any information related in any way to the Patient which you have transmitted to any company, public or private agency, or person; any other documents in your possession relating to examinations, hospital admissions, and diagnostic testing.
4) I understand that the information in my health record may contain information relating to sexually transmitted disease, and/or information about behavioural or mental health services, and treatment for alcohol and drug abuse.
5) This information may be disclosed to and used by Samaritan Fund Program, LLC.
6) I understand I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the health management department. I understand that revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company, when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire at the conclusion of legal representation.
7) I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form as a condition to enrollment or eligibility for benefits. I understand I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524.
8) I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.
9) A photostatic copy of this authorization shall serve in its stead.

I, _____ , declare under penalty of perjury that all statements contained in this request and any accompanying documents are true and correct.

_____ _____

Date Signature

Please submit completed form to: service@samaritanfundprogram.com