Blue Mountain Saint Hospital

311 Quarter Moore Ave, Beach Buff, CA, 19313

HIPAA Release Authorization

I, _____ _____, as a patient of _____, hereby authorize the release and disclosure of my protected health information (**PHI**) as defined by the Health Insurance Portability and Accountability Act (***HIPAA***) and its regulations.

The purpose of disclosure shall be; *(Please specify the purpose for which your PHI will be disclosed, such as medical treatment, insurance claims, legal proceedings, research, or any other specific purpose)*

The information shall only be disclosed to the receipents below;

- ☐ Healthcare Providers
- ☐ Health Insurance Companies
- ☐ Business Associates
- ☐ Family Members or Designated Representatives
- ☐ Researchers

This HIPAA Release Authorization is valid starting the date of my signature below and remains in effect until _____. I have been informed and understand that I have the right to revoke this authorization at any time by providing written notice. However, any disclosures made prior to the revocation based on this authorization will remain valid.

I understand that my failure to sign or the cancellation of this authorization does not avoid from receiving treatment, enrollment, or eligibility for or benefits I am entitled to receive, provided the information herein shall not be required in determining whether I am eligible to receive treatments or benefits or to pay for the services I receive.

Name of the Patient _____ _____

Date _____

Signature

_____

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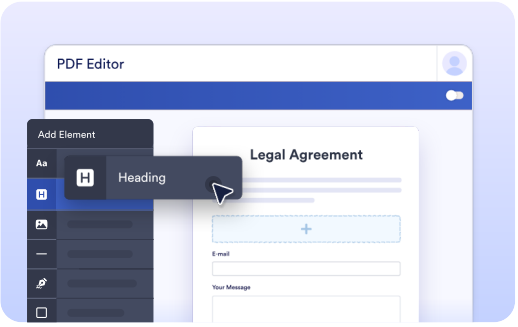

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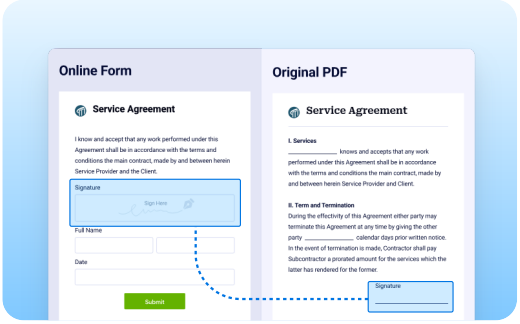

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