HIPAA AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I, _____ hereby authorize **USCB America** to disclose and release any and all of my individually identifiable information, which may include information to obtain, copy or inspect the following described information, data and/or records: all payment records, methods and records used to determine eligibility for SSI benefits, medical records, dialysis records, bills, psychiatric, psychological, drug and alcohol abuse records, HIV/communicable disease records, x-rays, hospital records, written histories, doctors' reports, mental health reports, psychiatric or psychological tests, assessments, raw data, test data, interview notes, recordings (audio and video), interviews with third parties pertaining to or that were used in the evaluation of, and any written or recorded medical, psychological and psychiatric information whatsoever concerning: communicable diseases such as Human Immunodeficiency Virus ("HIV") and Acquired Immune Deficiency Syndrome ("AIDS"), mental illness (except for psychotherapy notes), chemical or alcohol dependency, laboratory test results, medical history, treatment, billing, insurance or any other such related information.

I understand that this authorization is voluntary and I may refuse to sign this authorization. I further understand that my health care and the payment of my health care will not be affected if I do not sign this form.

_____

Patient's Name **Date of Birth** **Last 4 Digits of Social Security #**

Date(s) of service (if known): _____

Description of information to be released: See above.

All my health information as described above, unless specifically excepted: No exceptions

Reason or purpose of the use and/or disclosure: _____

The health information described herein shall be released to: (Check the appropriate category)

☐ Hospital ☐ Physician ☐ Insurance Company ☐ Attorney ☐ Patient ☐ Other

_____

Name **Address** **City** **State** **Zip**

I understand that this authorization will expire in 5 years unless I otherwise specify by date or by an event. I desire this authorization to be in effect until N/A (expiration event/date)

I further understand that I may revoke this authorization at any time by notifying Pat Esquivel, HIPAA Privacy Officer at USCB America 355 S GRAND AVE STE 3200 BOX 306 90071, in writing. I also understand that the written revocation must be signed and dated with a date that is later than the date on this authorization. The revocation will not affect any actions taken before the receipt of the written revocation.

It is further understood that there may be a fee for obtaining these records.

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_____ _____
Signature of Patient Date

_____ _____
Signature of Patient's Representative (If applicable) Printed name of Patient's Representative

_____ or _____
Relationship to Patient Legal Authority
(Attach Supporting Documentation)