AUTHORIZATION TO ACCESS PROTECTED HEALTH INFORMATION

EXCEPT FOR THE SIGNATURES AT THE BOTTOM OF THE PAGE, PLEASE PRINT ALL REQUIRED INFORMATION.

A. For the purpose of facilitating the management of my health care coverage, services, treatment, and bills, this form identifies in article D the family member or other individual who I am authorizing to access my Protected Health Information (PHI). My PHI is individually identifiable health information that relates to: my past, present or future physical or mental health or condition; the provision of health care to me; or the past, present or future payment for the provision of health care to me; and includes my entire medical record, but does not include psychotherapy notes.

B. I am aware of the following:

- If I authorize access **only to my on-line account**, the individual designated in article D will only have access to this on-line information as it pertains to the financial terms, diagnoses, procedures completed, providers used, and dates of service. NOTE: With this authorization type, on-line information is opened to the *person noted in Article D, including potentially other family members. Sharing of the password remains the responsibility & liability of the employee member.*
- If I authorize **full access** to my Protected Health Information, the individual designated in article D will have access to the on-line information ***as well as any and all*** **medical information and records** (which may contain information outlined in articles A & B as well as regarding testing/treatment of communicable or venereal disease and/or testing/treatment for psychological or psychiatric conditions or substance abuse) available through Med-Pay, Inc., the Third Party Administrator for my employer's employee group health care plan.

C. Indicate here the type of access you are authorizing *for the individual designated in article D,* below.

On-Line Access ONLY:_____ FULL PHI Access (including on-line):_____

D. **I** designate {his/her name}_____, {relationship}_____;

{address} _____; {SSN/DOB } _____

with authority to access my PHI as explained in A & B -- either for on-line only **or** with full access.

E. Unless otherwise cancelled by me, this access authorization will continue for a period of one (1) year from the date it is signed. I can cancel this form at any time by completing a removal request form. I understand that if any of my records or information has already been released because this authorization form was signed, I can't cancel those releases of records or information.

F. I release Med-Pay, its agents, and their employees from any liability in connection with the use or disclosure of the PHI covered under this Authorization.

G. ***I,*** _____ ***for myself as the insured, or on behalf of*** _____, a minor child or other individual for whom I am the legal representative, have had full opportunity to read and consider the contents of this authorization; and I confirm that the contents are consistent with my direction to Med-Pay, Inc. I understand that by signing this form I am confirming my authorization that Med-Pay, Inc., its agents and their employees may use and/or disclose my PHI to the individual named in article D of this form.

_____ _____

Signature of Insured or His/Her Legal Representative Date

Insured Address: _____

Insured SSN: _____ Insured Date of Birth: _____

Relationship to Minor Child/Other: _____ Group Name/Number: _____

WITNESS Name (printed) & Signature: _____ / _____

(Note: Witness cannot be any individual identified in articles D or G.)

A COPY OF THIS AUTHORIZATION SHALL SERVE THE SAME PURPOSE AS THE ORIGINAL.

Send to Med-Pay at: Suite 300, 1650 E. Battlefield Road, Springfield, MO 65804 or via fax to 417.890.0741.

REQUEST TO REVOKE AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Individual Making Request, if different from Participant: _____

Relationship of Requestor to Participant: _____

Participant Name: _____

Address: _____

Social Security Number: _____ Date of Birth: _____

Address to Send PHI _____

_____

Revocation of Limitation/Restriction Applies to: _____

Social Security Number: _____ Date of Birth: _____

REVOCATION OF AUTHORIZATION TO RELEASE INFORMATION

I, _____, hereby revoke the authorization to release information I provided to Med-Pay, Inc., that allowed Med-Pay to use and disclose my Protected Health Information as I outlined on the authorization form, which I signed on _____ for release of my Protected Health Information to _____. I understand that this revocation does not apply to any action Med-Pay, Inc., its contractor associates, or the employee group healthcare plan has taken in reliance on the authorization I signed earlier. This revocation does not revoke any and all previous authorizations to release information that I have provided to _____{Company/Med-Pay, Inc.}.

SPECIAL PROVISIONS – Participant: Please outline any special provisions, if any, regarding the revocation of the authorization.

_____
_____
_____
_____
_____
_____

_____ _____
Signature of Participant or Legal Representative Date

WITNESS NAME (printed) & SIGNATURE: _____
(Cannot be any individual(s) identified herein.)

Personal information contained on this form is collected pursuant to the HIPAA Privacy Rule, and will only be used for the purpose of responding to your request

A copy of this original shall serve the same purpose as the original.