HIPAA AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I, ____ (patient name) hereby authorize **Paid In Full, Inc.** 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 Name: ________________________________ **Date of Birth:** ____________ **Last 4 Digits of SSN:** _________

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

Description of information to be released: 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 (must check one):
❒Attorney ❒Patient ❒Other

Name: ____

____
Address **City** **State** **Zip**

I understand that this authorization will not expire 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 Paid In Full, Inc., PO Box 43228; Phoenix, AZ 85080, 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.

____ ____
Signature of Patient Date

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

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