49 Wireless Boulevard, Suite 140
Hauppauge, NY 11788

Phone: +1 (800) 226-3155 • Fax: +1 (863) 291-5010
www.medsaveusa.com

Authorization for Release of Information

Section I:

I authorize MedSave USA to use and disclose my protected health information as described below.

Member's Name: _____ Date of Birth _____/_____/_____

Address: _____ Telephone#: _____
(Street, City, State, and Zip Code)

Employee/Subscriber Name: _____ Employee/Subscriber ID: _____

Group Health Plan Name: _____ Group/ID Number: _____

My protected health information is individually identifiable health information, including demographic information, collected from me or created or received by a health care provider, a health plan, my employer, or a health care clearinghouse and relates to: (i) my past, present, or future physical or mental health or condition; (ii) the provision of health care to me; or (iii) the past, present, or future payment for the provision of health care to me.

I understand that this authorization is voluntary. I understand that my health information may be protected by the Federal Rules for Privacy of Individually Identifiable Health Information (Title 45 of the Code of Federal Regulations, Parts 160 and 164), the Federal Rules for Confidentiality of Alcohol and Drug Abuse Patient Records (Title 42 of the Code of Federal Regulations, Chapter I, Part 2), and/or state laws. I understand that my health information may be subject to re-disclosure by the recipient and that if the organization or person authorized to receive the information is not a health plan or health care provider the information may no longer be protected by the Federal privacy regulations.

I understand that my health information may contain information created by other persons or entities including health care providers, and may also contain drug and alcohol, mental health, HIV/AIDS, psychotherapy, reproductive and sexually transmitted disease information. I further understand that by signing this document, I am authorizing the release or exchange of this information with the person or organization named below.

I understand that my health plan may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this form, except for certain eligibility or enrollment determinations prior to my enrollment in its health plan, and for health care that is solely for the purpose of creating protected health information for disclosure to a third party.

Section II:

The protected health information that may be used and disclosed is as follows:

☐ Claims ☐ Eligibility/Benefits ☐ Treatment Plan(s) ☐ Medical Records

☐ Progress Reports ☐ Information for benefit determinations ☐ All

☐ Other (describe in detail): _____

☐ Date of Service(s) to be disclosed: From: _____ To: _____

Include information pertaining to (check any that apply and that you wish to be disclosed):

☐ Mental Health ☐ HIV/Aids ☐ Alcohol/Drug Rehabilitation ☐ STD/Reproductive Treatment

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Section III:

The following Individual(s), Provider(s), or Organization(s) is authorized to receive my protected health information:
(Please list the specific names and relationship if possible)

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Section IV:

I authorize MedSave USA, Inc. to release my protected health information to the individuals listed on this form. I understand that if my protected health information is to be received by individuals or organizations that are not health care providers, health care clearinghouses, or health plans covered by federal privacy regulations, my protected health information described above may be re-disclosed and no longer be protected by federal privacy regulations.

I understand that I may refuse to sign this authorization. I further understand that my group health plan will not condition enrollment in the plan or eligibility for benefits on my signing this authorization.

I also understand that I may revoke this authorization at any time by sending a written notification to MedSave USA, Inc. and this revocation will be effective for future uses and disclosures of protected health information. However, I further understand that this revocation will not be effective for information that was previously used or disclosed, relying on this authorization.

Section V:

This authorization will expire on the date indicated below. If no date is specified, this authorization will expire at the termination of coverage.

Date of expiration of authorization: _____/_____/_____

NOTE: This form should be signed by the member. If the member is unable to sign, a Legal Representative may sign on their behalf. The Legal Representative shall submit the completed form along with a copy of their legal documentation appointing them as Legal Representative for the member.

Name: _____ **Signature:** _____ **Date:** _____
(Print of Member/ Guardian/ Member Representative)

Name: _____ **Signature:** _____ **Date:** _____
(Print of Member/ Guardian/ Member Representative)

Name of Personal Representative: _____

Description of Personal Representative Authority: _____

Mail or fax completed form to:

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