Health Aid Company, Inc.

Authorization for Release of Protected Health Information (PHI)

I hereby authorize the use or disclosure of my individually identifiable health information as described below.

1. PERSONAL INFORMATION:

Patient Name: _____ Social Security #: _____

Date of Birth: _____ Phone #: _____

2. AUTHORIZES:

_____
Name of Health Care Provider/Plan/Other

_____
Street Address

_____
City, State, Zip Code

3. RELEASE INFORMATION TO:

Health Aid Company, Inc.
4502 North Armenia Ave
Tampa, FL 33603
Phone: 813-879-7552 Fax: 813-876-2621
1280 Missouri Ave N
Largo, FL 33770
Phone: 727-586-2995 Fax: 727-588-0899
Tax ID: 59-1533206

4. DESCRIPTION OF INFORMATION TO BE RELEASED:

☐ Entire medical record
☐ Medical records for specific date(s) of service; from _____ to _____.
☐ Progress notes
☐ Other _____.

5. PURPOSE OF INFORMATION:

☐ Insurance eligibility/benefits
☐ Personal use – at the request of the individual
☐ Further medical care
☐ Legal investigation

6. EXPIRATION DATE: This authorization will expire on _____.

***** If expiration date is left blank, Health Aid Company, Inc. will assume that you are indicating no expiration.

7. The patient has the right to revoke this authorization, except to the extent that action has been taken in reliance on this authorization, prior to the above date. In order for the revocation of this authorization to be effective, Health Aid Company, Inc. must receive the revocation in writing. The revocation must include the following information: 1. Patient's name, address, and social security #, 2. effective date of this authorization, 3. recipients of the health information according to this authorization, 4. patient's desire to revoke this authorization and 5. date of the revocation and the patient's signature.

8. I understand that if the person(s) and/or organizations(s) listed above are not health care providers, health plans or health clearinghouses, who must follow the federal privacy standards, the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and my health information may be disclosed without obtaining my permission. I fully understand and accept the terms of this authorization.

9. _____ _____
Date Signature of Patient or Representative

10. If applicable, please complete the following:
Patient is: ☐ Minor ☐ Incompetent ☐ Disabled ☐ Deceased
Legal Authority: ☐ Custodial Parent ☐ Legal Guardian ☐ Authorized Legal Representative
☐ Executor of Estate of Deceased ☐ Power of Attorney for Healthcare

If any person other than the patient is signing this form, proof of authority must accompany the form.

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION