HME Specialists LLC

Infusion Therapy Services
Specialty Mobility Services
Home Medical Equipment
Respiratory Services
Retail Store Front

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

PATIENT NAME:

PATIENT ADDRESS:

PATIENT ID: PATIENT DOB:

1) I authorize the use or disclosure of health information for the above named individual.

2) I authorize HME Specialists, LLC to make the disclosure.

3) The type and amount of information to be used or disclosed is:

☐ Entire Record

☐ Other (*minimum necessary information*): _____

_____

4) The following individual or organization may receive and use the authorized information.
Name: _____
Address: _____

5) This information will be disclosed for the following purposes(s):

_____

6) I understand that I can stop this authorization, at any time. I understand that to stop this authorization, I must provide HME Specialists LLC with a written request. I understand that my request to stop authorization will not apply to information that has already been released in response to this authorization. I understand that my request to stop the authorization will not apply to my insurance company, when the law gives my insurer the right to contest a claim under policy.

7) This authorization will expire (12)-twelve months from the date of signing if an expiration date, event, or condition is not specified:

_____

8) I understand that once my information is disclosed according to this authorization, the recipient may redisclose it; and the information may not be protected by federal privacy regulations.

9) I understand that I will get a copy of this authorization form, after I sign it.

10) I understand that HME Specialists LLC cannot refuse treatment, if I refuse to sign this form.

_____

Signature of Patient or Legal Representative Date Signed

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