Authorization to Release of Health Information to Third Party and Financial Disclosure

Patient Name:_____ DOB:_____

I, or my authorized representative, requests that the health information (PHI, etc) regarding my care and treatment be accessed, used, and/or disclosed as stated on this form. In accordance with the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

a. I have the right to revoke this authorization and my permission to send information to said parties by writing to info@ihelpnonprofit.org stating my name, DOB, and request to cease transfer of information between iHelp (International Healthcare Enrichment and Learning Project, inc.) and said 3rd party. Prior information transmitted across parties at my permission will be held by the third party and is not the responsibility of iHelp. This authorization will last for 12 months unless requested to cease beforehand. PHI is information as specified on FL department of health website.
b. I understand that signing this Authorization is voluntary. My treatment or edibility will not be conditioned upon my authorization of this disclosure.
c. Information disclosed under this authorization may no longer by protected by federal or state law. However, if I am authorizing the release of substance abuse treatment, mental health treatment, or HIV-related information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law.
d. iHelp is not responsible for protecting PHI under the care of other entities including the third party I authorize iHelp to share PHI with.
e. iHelp does not carry encrypted email servers currently. PHI will be shared as photocopied paper copies to the intended recipient or may be emailed at the recipient's request. Please not that email is not a secured method of communication.
f. Under Florida law, physicians are generally required to carry medical malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice. However, certain part-time physicians who meet state requirements are exempt from the financial responsibility law. Your doctor meets these requirements and has decided not to carry medical malpractice insurance. This notice is provided pursuant to Florida Law.

I fully understand the above and allow iHelp to disclose my information to:

_____

Patient Signature:_____ (Date:_____ Time_____

Signature Of Interpreter:_____ (Date:_____ Time_____