

Authorization for Use or Disclosure of Protected Health Information

I, _____ authorize the use/disclosure of health information about me as described below.

1. Person(s) or class of persons authorized to use/disclose the information:

Scout Master, and Assistant Scout Master(s) of Troop 1412, Health practitioners such as Emergency room technicians, Registered Nurses(R.N.), License vocational nurses (L.V.N.), Pharmacists, and Physicians.

2. Person(s) or class of persons authorized to receive the information:

Scout Master, and Assistant Scout Master(s) of Troop 1412, Health practitioners such as Emergency room technicians, Registered Nurses(R.N.), License vocational nurses (L.V.N.), Pharmacists, and Physicians.

Pharmacists, Physicians,

3. Description of information that may be used/disclosed:

Allergies, Medical History, Prescriptions, Prescription lists, Laboratory results, Medical information, Studies, Scans, Consults, Physical exams, Authorization documents, Billing information, Invoices, Letters of medical necessity, HCFA 1500 forms, Medi-cal 301 forms, Electronic billing, Certificate of medical necessity, Patient's name, Patient's address, Patient's phone number, Patient's social security number, Patient's Medi-cal number, Patient's Medicare number, Patient's date of birth, Patient's height, Patient's weight, Patient's age, Patient's ICD-9 codes, Patient's insurance provider.

4. The information will be used/disclosed for the following purposes:

To communicate with other healthcare practitioners(physicians, pharmacists, nurses, podiatrists, dentists, ophthalmologists) To facilitate reimbursement of emergency room/hospital/medical/pharmacy claims(insurance providers including but not limited to Medicare/Medi-cal.)

5. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and no longer protected by these regulations.

6. I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization form. I may arrange to inspect my health information or obtain copies of my health information by contacting Rudy Silva, Scout Master or the privacy officer(s) Troop 1412.

7. I understand that if I agree to sign this authorization, which I am not required to do, I must be provided with a signed copy of this form.

8. I understand that I am under no obligation to sign this form and that the person(s) and/or organization(s) listed above whom I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization.

9. I understand written notification is necessary to cancel this authorization. To obtain information on how to withdraw my authorization or to receive a copy of my withdrawal, I may contact: Rudy Silva, Scout Master Troop 1412 and or the privacy officer(s). I am aware that my withdrawal will not be effective as to uses and/or disclosures of my health information that the person(s) and or organization(s) listed above have already made in reference to this authorization. This authorization expires in 6 years(March, 2012).

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_____ (Please initial)

Patient's Name

Signature of Patient or Representative

Date

Name of Personal Representative (if applicable) Relationship to Patient

(A copy of this signed form is provided to the patient)

I, _____ have been provided with a copy of this form, "Authorization for Use or Disclosure of Protected Health Information"(PHI)

Patient's Signature
W:\WPDOCS\BSAHIPPA.DOC

Date