ROSE & KIERNAN, INC.
99 Troy Rd. East Greenbush, NY 12061
Fax: (518)244-4262


# Authorization to Use and/or Disclose HIPAA Protected Health Information

**Form Received By** _______________ **Date** ___________

| 1. Name of Plan Participant | 1a. Name of Health Plan |
|---|---|
| 1b. Date of Birth | |
| 2. Name of Person Whose Health Information is the Subject of this Authorization | 2a. Relationship to Plan Participant<br>☐ Self ☐ Spouse ☐ Child ☐ Other |
| 3. Name of Person Completing Authorization | 3a. Authority<br>If you are not the person in Box 2, please describe your authority to act on his or her behalf:<br>________________________________________<br>________________________________________<br>______________ |
| 4. Mailing Address | 4a. City, State, Zip Code |

I hereby authorize **Rose & Kiernan, Inc.** to use and/or disclose the health information described in Sections A — E below.

### Section A: Health Information to be Used and/or Disclosed.

Specify the health information to be released and/or used, including (if applicable) the time period(s) to which the information relates. Select only one (1) of the following boxes:

☐ All of my past, present or future health claims and/or medical records.

☐ All of my health information relating to Claim Number ________________.

☐ Other (please specify).________________________________________
________________________________________

### Section B: Person(s) Authorized to Use and/or Receive Information.

Specify the persons or class of persons authorized to use and/or receive the health information described in Section A:

________________________________________.

### Section C: Purposes for Which Information will be Used or Disclosed.

Specify each purpose for which the health information described in Section A may be used or disclosed. Select all of the applicable boxes below:

☐ To facilitate the resolution of a claim dispute.

☐ At my request.

☐ Other (please specify).________________________________________

### Section D: Expiration of Authorization

Specify when this Authorization expires. (Provide a date or triggering event related to the use or disclosure of the information.)

☐ On the following date: ______________________.

☐ Upon the passage of the following amount of time: ______________________________.

☐ Upon my disenrollment from the health plan identified in Box 1a above.

☐ Other (please specify)______________________________________________________________________________
______________________________________________________________________________

**Your rights:**

- You can revoke this Authorization at any time by submitting a written revocation to Rose & Kiernan, Inc. at the following address:

  ____________________________________________________________________

  ____________________________________________________________________

- A revocation will not apply to information that has already been used or disclosed in reliance on the Authorization.
- Once the information is disclosed pursuant to this Authorization, it may be redisclosed by the recipient and the information may no longer be protected by HIPAA.
- The plan may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign the Authorization.
- You will be provided with a copy of this Authorization, after signing.

____________________________________________________
**Signature of Participant & Date**

April 2008