HIPAA Release of information AUTHORIZATION FORM

I, _____ hereby authorize the release of my personal health information relating to the diagnosis, treatment, claims payment, and health care services provided to MARGARET'S PLACE, its affiliates, its employees and agents, which identifies my name, address, social security number, Member ID number for the purpose of helping me to resolve claims, health benefit coverage issues, Life Coaching sessions, Physical therapy sessions and any other services provided by MARGARET'S PLACE . I understand that any personal health information or other information released to the person or organization identified above may be subject to re-disclosure by such person/organization and may no longer be protected by applicable federal and state privacy laws. This authorization is valid from the date of my/my representative's signature below until revoked. I understand that I have a right to revoke this authorization by providing written notice to MARGARET'S PLACE. However, this authorization may not be revoked if MARGARET'S PLACE, its employees or agents have taken action on this authorization prior to receiving my written notice. I also understand that I have a right to have a copy of this authorization. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment or payment for or coverage of services.

Name of Member: _____

Signature of Member: _____ Date:_____

If applicable, Legal Representatives sign below: By signing this form, I represent that I am the legal representative of the Member identified above and will provide written proof (e.g., Power of Attorney, living will, guardianship papers, etc.) that I am legally authorized to act on the Member's behalf with respect to this authorization form.

Name of Legal Representative: _____

Signature of Legal Representative: _____

Date: _____

Name of Witness: _____

Signature of Witness: _____