Authorization for Release of Information

HIPAA Privacy Authorization Form (Required by Health Insurance Portability Act, CFR Parts 160 and 164)

Name: DOB

Authorization

I authorize the following healthcare provider to disclose protected health information to Richard White Insurance, and their licensed agents for all past, present, or future periods.

I authorize the release of my complete health record (including records relating to mental healthcare communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).

Healthcare Provider: Phone Number :

Extent of Authorization

This medical information may be used by Richard White Insurance LLC and their agents for consultation, billing and claims payment, or other purposes as I may direct.

This authorization shall be in force and effect until I request, in writing, that it be withdrawn.

I understand I have the right to revoke the authorization in writing at any time. I understand revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand any treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

I understand that information used or disclosed by the recipient may no longer be protected by Federal or State law.

Release Information to Richard White Insurance LLC and their licensed agents
1801 Forest Hills Blvd. Suite 126 Bella Vista, AR 72715
Phone 479-372-0274 Fax 479-957-9063

Release for
Insurance Purposes ◯ Other ◯

Consent:

I understand that this release is valid when I sign it and that I may withdraw my consent at any time in writing.

Signature: