



H.H.C. Group

Health Insurance Consultants™

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HIPAA AUTHORIZATION AND CONSENT FOR RELEASE OF INFORMATION

TO: _____
EFFECTIVE DATE: _____

This will authorize you to release to Roffe Enterprises, Inc. t/a H.H.C. Group ("H.H.C. Group") and its agents thereof, all medical records of whatever nature, mental health records, billing statements, radiological films, pathology material, photographs, videos, and other information concerning:

PATIENT: _____ **DOB:** _____
SSN: _____ **DATE OF SERVICE:** _____

This will also authorize you to speak to and disclose orally any information relating to diagnosis, care, treatment prognosis, opinions, payments and discounts with regard to the above to H.H.C. Group or any employees/agents of H.H.C. Group.

The purpose of the release and disclosure of this information is at the request of below the patient/individual.

I understand that I may specify a date for the expiration of this authorization, but that it shall expire by law, without my express revocation, one year from the Effective Date referenced above. Revoking this authorization will not have any effect on actions that the health care provider took in reliance on this or any authorization before the health care provider received notice of the revocation. The information to be disclosed may be protected by law. Information disclosed under this authorization may be re-disclosed by the recipient and no longer protected by federal privacy regulations. I understand that my ability to receive health care treatment from the health care provider will not be affected if I do not sign this form. However, without my signature, this request to release the information described above will not be honored. The protected health information provided under this authorization may include diagnosis and treatment information, including information pertaining to chronic diseases, behavioral health conditions, alcohol or substance abuse, communicable diseases (including HIV/AIDS) and/or genetic marker information. These records will be included in the information we will make available to the individual or organization I have identified above.

Patient and/or Legal Guardian

Date

Note to Health Care Providers: This authorization is provided in compliance with HIPAA. Failure to forward the requested information may render a health care provider liable for damages.

A PHOTOGOPY OF THIS AUTHORIZATION MAY BE USED IN LIEU OF THE ORIGINAL