

AUTHORIZATION FORM FOR USE & DISCLOSURE OF HEALTH INFORMATION

COAST Rehab is required by law to maintain the privacy of our members' health information. Unless you have signed a form authorizing the use or disclosure; we will not use or disclose your health information for any purpose other than COAST's role in treatment, payment or for health care operations. With your written approval, we may disclose your health information to others, including designated family, friends or others who are involved in your health care or in payment for your health care. This form allows you to designate this/these person(s). A copy of this form is as valid as the original.

A separate form must be completed for each adult family member/applicant, including dependents age 18 and over.

I, _____, hereby authorize the use or disclosure of health
(print member/applicant name)
information about me as described below.

As the parent, I authorize the use or disclosure of health information about my minor dependent(s), age 17 and under as described below.

_____, _____, _____
(print dependent(s) full name)

1. Person(s) or group of persons authorized to disclose the information:
 - COAST
2. Person(s) or group of persons authorized to receive and use the information from COAST
 - Your insurance company.
 - Family and friends: check all that apply if you wish a family member or friend to be able to discuss your coverage and claims with COAST, and to receive health information which COAST maintains about you:
 - Spouse: write in name and address _____
 - Family member: write in name, address, & relationship _____
 - _____
 - Friend(s) or other(s): write in name, address, & relationship _____
 - _____
3. Description of the information that may be used or disclosed:
 - All health information pertaining to me or my minor dependent(s), if applicable, related to the diagnosis, treatment or prognosis with respect to any physical, accident, illness, medical or mental condition and any other plan related information.

(over)

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(continued)

4. I understand that if the person or entity that receives the information described herein is not a health care provider or health plan covered by federal privacy regulations, the information described here may be redisclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.
5. If the person completing this authorization is the personal representative of the member/ applicant or dependent, describe your authority to act on this person's behalf.
- _____
- _____
6. I understand that I am not required to sign this authorization form and that COAST will \ not refuse/discontinue treatment to me by not signing this authorization.
7. I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken by COAST in reliance on this authorization by sending a written signed and dated revocation to COAST.
8. I understand that either I or my personal representative, may receive a copy of this authorization upon request and that I may inspect or copy the information to be used or disclosed.

Member/Applicant Signature

Date_____

Personal Representative Name, if applicable

Personal Representative Signature

Date_____