Rapport Benefits Group

HIPAA Authorization for Release of Protect Health Records

This document authorizes Rapport Benefits Group to request, receive, and disclose protected health information in order to assist you with your benefits according to the HIPAA, 45 C.F.R. parts 160 & 164.

Patient Name _____ Insurance ID # _____

Primary Insured Name _____ Relation _____ Insurance ID # _____

Patient Date of Birth _____ Primary Insured Date of Birth _____

The following people are hereby authorized to receive and disclose Protected Health Information about me

- ☐ Rapport Benefits Group Employees
- ☐ Other _____

Please list the name of the entity or entities authorized to release information

_____ _____

I authorize the above group or individual to disclose the following types of information

- ☐ Enrollment and Eligibility Information
- ☐ Claims, Claim Status, and Claim History
- ☐ Premium and Billing Information
- ☐ Other _____

I authorize the above group or individual to disclose the following information regarding health conditions

- ☐ All Health Records of Any Kind
- ☐ Communicable Diseases (HIV, AIDS, etc.)
- ☐ Substance Abuse (Alcohol and Drugs)
- ☐ Mental Health Treatment & Diagnosis
- ☐ Other _____

The purpose of this disclosure is

- ☐ To assist me in understanding my benefits
- ☐ To assist me with the resolution of claims
- ☐ Other _____

This authorization includes health records from _____ to _____.

This authorization expires on _____. (if blank, authorization expires 24 months after signature)

I understand that this medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

I understand that completion of this form is not a requirement to receive treatment, payment or eligibility. Rapport Benefits Group is not responsible for any action taken by an authorized recipient of my protected health information. I am aware that an authorized recipient may re-disclose my information and the privacy protections provided by law may be lost.

I understand I may cancel this authorization at any time by sending written notice to Rapport Benefits Group. Cancellation of this authorization will not affect any actions taken by Rapport Benefits Group before receiving my cancellation notice.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Patient Signature _____ Date _____

If this authorization is signed by a person acting on behalf of another person, please complete the following and attach documentation demonstrating your authority to act on behalf of another. (power of attorney, guardianship, conservatorship etc.)

Signature of Personal Representative _____ Phone _____

Name of Personal Representative _____ Relation _____ Date _____