optimhealthcare

HIPAA Disclosure Authorization Form

Full Name _____
(Patient)

I hereby authorize **OPTIM HEALTHCARE** and its affiliates, its employees, and agents to use or disclose my protected health information related to and including, but not limited to, diagnosis, treatment, claims payment, and health care services provided or to be provided to me and which may identify my name, address, and other individually identifiable health information

to _____ for the purpose of:
(Recipient)

- I understand that, at any time, this authorization may be revoked by submitting a written revocation to:

  [OPTIM PRIVACY OFFICER]
  210 DeRenne Avenue
  Savannah, GA 31405

- However, that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my health care will not be affected if I refuse to sign this form.
- I understand that information used or disclosed, pursuant to this authorization, could be subject to redisclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

_____ _____
Date Signature of Patient or Legal Representative

_____
Authority or Relationship to Individual, if Legal Representative ***(By signing this form, I represent that I am the legal representative of the Patient 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 Patient's behalf with respect to this authorization form.***

EXPIRATION DATE: This authorization will expire on _____

If an expiration date is not provided, this authorization shall be in force six (6) years from the date this authorization is executed by either the Patient/Member or appropriate legal representative.