

Notice to Patient

You may revoke this authorization at any time. To revoke this authorization, send a written statement to the BHHF Privacy Official or Designee(s), ADDRESS, CITY, STATE, ZIP. The statement must identify this authorization by referring to the date it was signed (below). The statement must include the date on which this authorization is no longer in force.

If you revoke this authorization, we may still use and disclose the information for the purposes listed above, if we have already taken action in reliance on this authorization. Also, if this authorization is to permit BHHF to disclose information to an insurance company, in order for you to obtain insurance coverage, the insurance company may still have the legal right to use the information to contest a claim or to contest your coverage.

You may refuse to sign this authorization. You do not need to sign this authorization to receive services from BHHF EXCEPT in the following circumstances:

- If the only purpose for providing you with a service is to obtain information to disclose to someone else, then you must authorize that disclosure in order to receive the service. (Example: physical examinations required to obtain certain types of licenses.)
- If the services are related to research, you may be required to authorize the use or disclosure of your health information for the research. This applies only to health information related to the research services. The use and disclosure of your information will be limited to what is necessary for the research. If you do not authorize the use and disclosure of your information for the research, you may not be eligible to receive the services.

You do not have to sign this authorization to receive payment, to enroll in BHHF's health plan, or to be eligible for benefits, except:

- If this authorization is sought is for the purpose of determining your eligibility for benefits or enrollment, then you must authorize BHHF to obtain the necessary information or the benefits or enrollment may be denied.
- If this authorization is sought is for the purpose of underwriting or risk rating determinations, then you must authorize BHHF to obtain the necessary information or benefits or enrollment may be denied.
- Under Federal law, you do not have to authorize us to receive the private notes from counseling sessions, that are kept by a mental health professional, as a condition of payment, enrollment in a health plan, or eligibility for benefits.

A person or organization that receives your information because of this authorization may have the legal right to disclose this information to other people or organizations without your knowledge or consent.

Signature: _____ Date: _____

If this authorization is signed by someone who is not the patient listed at the top of this form, provide a description of the signer's authority to act for the patient.

The patient will be provided with one copy of this form.

Form Auth 01- 04/1

BHHF
AUTHORIZATION
TO USE AND DISCLOSE
PROTECTED HEALTH INFORMATION

PATIENT

Name: _____

Date of Birth: _____

ID Number: _____

DESCRIPTION OF INFORMATION TO BE USED OR DISCLOSED:

WHO IS AUTHORIZED TO USE OR DISCLOSE THE INFORMATION?

WHO IS AUTHORIZED TO RECEIVE THE INFORMATION?

REASON THE INFORMATION WILL BE USED OR DISCLOSED [if the patient initiates the authorization, the statement "at the request of the individual" is sufficient]:

If the purpose listed above includes "marketing," BHHF **will** or **will not** receive payment as a result of using or disclosing this information. This does not include payment for any services provided to you.

EXPIRATION DATE OR EVENT: _____