HIPAA Patient General Release of Information

This release hereby authorizes a representative of Medivest Benefit Advisors, Inc. to speak with and obtain information from my treating physician(s), hospital(s) or other health care provider(s), including any commercial and/or private health insurance provider(s), or Medicare Set-Aside allocator(s) for the purpose of determining benefit eligibility in the reviewing and processing of claims. Information authorized will include, but is not be limited to, any and all past and future medical information, psychological care needs/services, including doctor/physician reports and records, diagnostic images, medical evaluations, billings, invoices and payment records, etc.

I understand that information used or disclosed may be subject to re-disclosure by the entity receiving it and would then no longer be protected by federal privacy regulations.

I may revoke this authorization at any time by notifying Medivest Benefit Advisors, Inc. in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions. This authorization shall expire when the account being professionally administered by Medivest Benefit Advisors, Inc. permanently exhausts, no future monies are forthcoming, the account balance is zero and the account closes.

I agree that a photostat copy of this authorization shall be considered as effective and valid as the original.

PATIENT SIGNATURE

Patient Signature: _____ Date: _____

Print Name:_____

LEGAL REPRESENTATIVE (If not signed by Patient)

Signature: _____ Date: _____

Print Name:_____

NOTE: If a legal representative of the patient signs this authorization, a description of such representative's authority to act for the individual must also be provided.

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