Authorization to Use or Disclose Protected Health Information (PHI)

I. Individual

Patient Name: ____ Date of birth: _______________

II. Disclosing Party

Records Custodian
Provider Name: ____
Provider Address: ____
____

III. Authorization and Purpose

a. The Disclosing Party may use or disclose the following protected health care information to the Receiving Party listed below (check all that apply):

☐ My complete medical record for services rendered on or after the following date: ___________________________

☐ Other:____

Important note: Unless this authorization is expressly limited, this authorization grants the healthcare provider the right to disclose all personal medical information for the purpose described, including medical information about any diagnosis or treatment for mental health, substance abuse, sexually transmitted diseases (such as HIV), and cancer.

b. Purpose for this authorization (check all that apply):

☐ Compliance with Medicare Secondary Payer Act related to my injury claim

☐ Other:____

IV. Receiving Party

Axiom National, LLC, 13046 Race Track Rd #277, Tampa, FL 33626

Telephone: 888-826-6496; Facsimile: 813-920-6946

V. Signature

______________________________________ ______________________________

Patient or legally authorized individual signature | Date Signed

If signed as a Power of Attorney or Legal Guardian, I have completed the following and attached a copy of the legal documentation.

______________________________________ ______________________________

Printed Name if signed on behalf of the patient | Relationship (legal guardian, personal representative, etc.)

VI. Revocation, Expiration and Privacy Laws

I may revoke this authorization by notifying the Disclosing Party in writing of my desire to revoke it. I understand that the revocation will not affect any actions already taken by the above-named provider based upon this authorization. I understand that the information used or disclosed to the Receiving party may be re-disclosed and the Protected Health Information would no longer be protected by federal and/or state privacy laws and regulations.

This authorization will expire one year from the date signed. A photocopy of this authorization is valid.