VIP STRATEGIES LLC
HIPAA COMPLIANT AUTHORIZATION

Patient Authorization for Release of Health Records to External Parties

Name: _____ Date of Birth: _____

Card ID: _____ SSN: _____

I hereby give permission to _____ and its contract representatives to share the health information listed below with VIP STRATEGIES LLC.

The purpose of this disclosure is to determine any lien amount that is related to a claim or lawsuit.

The information to be disclosed is any and all medical records and/or billings.

This authorization will expire on _____. In the event you do not enter a date, this authorization will expire in five (5) years from the executed date below.

I understand that the information in my health records may include information related to sexually transmitted disease, acquired immunology syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental services, and treatment for alcohol and drug abuse.

I understand that I may withdraw or revoke my permission at any time. If I withdraw my permission, my information may no longer be used or released for the reasons covered by this authorization. However, any disclosures already made with my permission are unable to be taken back. I may revoke this authorization by notifying the appropriate entity in writing.

My treatment will not be based on the completion of this authorization form. The information to be released by this authorization may be re-released by the person or organization that receives it and may no longer be protected by federal or state privacy regulations.

I release the individual or organization named in this authorization from legal responsibility or liability for the disclosure of the records as authorized on this form. I understand that this authorization is voluntary and that I may refuse to sign it. I will be provided a copy of this signed authorization, if requested. A photocopy of this authorization is as valid as the original.

_____ _____
Signature Date

_____
Printed Name of Patient

By signing this form, I represent that I am the legal representative of the member 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 member's behalf with respect to this authorization form.

_____ _____
Signature of Legal Representative Date

_____
Printed Name of Legal Representative