

IDXRNR \_\_\_\_\_

Facility \_\_\_\_\_

Date Received: \_\_\_\_\_

**MBFS**  
4535 Dressler Rd. NW, Canton, OH 44718  
1-800-982-8177 Fax (330) 492-8489

**MBFS**  
3300 Douglas Blvd., Ste 200 Roseville, CA 95661  
1-888-530-9480 Fax (916) 543-1135

**AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION**  
**45 CFR 164.508(c)**

- I authorize my health care provider and his/her medical billing company, Medical Billing and Financial Services, Ltd. (MBFS), to use and/or disclose the medical and billing information about me described below.
- My health care provider and MBFS are authorized to disclose my health information to the following individual(s) and/or organizations such as carriers, insurance companies, law firms, etc.: (Must fill out)  
\_\_\_\_\_  
\_\_\_\_\_
- I would like my health information disclosed for the following reason(s): \_\_\_\_\_  
\_\_\_\_\_
- The information that may be used and/or disclosed is: (Must check one)  
\_\_\_\_ Any and all medical and billing records concerning all medical care that I have ever received from my health care provider  
\_\_\_\_ Any and all medical and billing records concerning medical care I received from my health care provider on: \_\_\_\_\_  
\_\_\_\_ Other: \_\_\_\_\_
- The following items must also be checked to be included in the use and/or disclosure of health information pursuant to this Authorization:  
\_\_\_\_ (a) HIV/AIDS related information and/or records      \_\_\_\_ (c) Genetic testing information and/or records  
\_\_\_\_ (b) Mental health information and/or records      \_\_\_\_ (d) Drug/alcohol diagnosis, treatment and referral information
- I understand that if a person or entity that receives information pursuant to this Authorization is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and is no longer protected by those regulations. Therefore I release EMP therefore, I release my health care provider, his/her employer and MBFS from all liability arising from this disclosure of my health information.
- I understand that I have the right to revoke this Authorization, in writing, at any time by sending such written notification to the Privacy Officer at 4535 Dressler Road, N.W., Canton, OH 44718. I understand that a revocation is not effective to the extent that my health care provider and MBFS have already taken action in reliance upon this Authorization.
- I understand that I may refuse to sign this Authorization and that my refusal to sign will not affect my ability to obtain treatment, payment or my eligibility for benefits.
- This Authorization will expire six (6) years from the date signed below, or \_\_\_\_\_, whichever is earlier.

\_\_\_\_\_  
Patient's Name (Please Print)

\_\_\_\_\_  
Name of Patient's Personal Representative/Guardian, If Applicable (Please Print)

\_\_\_\_\_  
Address of Patient

\_\_\_\_\_  
Address of Personal Representative/Guardian

\_\_\_\_\_  
Social Security No.:

\_\_\_\_\_  
Description of Representative's Authority to act for the Patient

\_\_\_\_\_  
Account No.:

\_\_\_\_\_  
Signature of Personal Representative/Guardian

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date:

\_\_\_\_\_  
Date:

## INSTRUCTIONS FOR COMPLETING THE HIPAA AUTHORIZATION FORM

Our Authorization Form has been designed to comply with requirements contained in the federal privacy regulations, known as HIPAA, concerning protected health information that went into effect on April 14, 2003. (*See* 45 CFR 164.580(c))

The patient or the patient's personal representative must complete and sign the Authorization. While we do not provide legal advice and individual situations vary, personal representatives may include a patient's parents, spouse or adult children, as well as individuals who hold a power of attorney or who are responsible for handling a patient's estate.

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**Please read each item of the Authorization carefully before completing any blank spaces.**

- Item No. 2:** The patient or the patient's personal representative must tell us the specific names of the individuals or organizations to whom we are authorized to release the information. (Ex: John Doe (spouse), Jane Doe (daughter), Allstate Auto Insurance, The ABC Law Firm, etc.).
- Item No. 3:** You need to tell us why you would like us to release the information. (Ex: to get a claim paid by auto insurance, my spouse takes care of my medical bills, etc.).
- Item No. 4:** Check the appropriate box to help us identify the date of service and type of information to be released. Please note that while we own and maintain billing records concerning the medical care we provide, we do not own medical records. Medical records are owned and maintained by the facilities where we provide care. Authorizations for the release of medical records need to be directed to the Medical Records Department at the appropriate facility.
- Item No. 5:** If the type of information identified in section five does not apply, it is not necessary to complete section 5. If the items do apply, and you do not want us to disclose this type of information, do not complete Section 5. If the items do apply, and you want us to disclose the information to a third party, please place check marks in the appropriate spaces.
- Item No. 9:** Please note that this release will expire six years from the date that it is signed by the patient or the patient's personal representative UNLESS an earlier date is placed in the blank.

**Please remember to sign and date the authorization.** The patient or the patient's personal representative must complete and sign this section.

If you have any trouble filling out this authorization, or if you have any questions, please call our Customer Service Department.

**Eastern U.S. Facilities** 1-800-982-8177 between 7 AM and 4:45 PM Eastern Time, Monday-Friday.

**Western U.S. Facilities** 1-888-530-9480 between 8 AM and 5:15 PM Pacific Time, Monday- Friday.