CHRISTIAN HEALTH AID HIPAA AUTHORIZATION FORM

Patient's Full Name	**Patient's Social Security Number/Medical Record Number**
Address	**Patient's Date of Birth**
City, State Zip	**Patient's Telephone Number**

I hereby authorize physicians, hospitals, and other medical personnel to disclose protected health information about me to Christian Health Aid/Century Health Alliance for the purpose of determining eligibility and negotiating payment.

UNLESS YOU SIGN HERE, NO INFORMATION ABOUT ALCOHOL/SUBSTANCE ABUSE, HIV/AIDS, OR MENTAL HEALTH WILL BE DISCLOSED:
YES, DISCLOSE THIS INFORMATION *_____
NO, **DO NOT** DISCLOSE THIS INFORMATION * _____

1. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations.
2. I may revoke this authorization by notifying the provider/hospital/medical personnel 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.
3. This authorization will expire in one (1) year unless revoked in writing.

THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING

_____	_____	_____
Signature of Individual* (The person about whom the information relates)	**Date of Individual's Signature**	**Date of Birth or Social Security Number**

OR, if applicable –

_____	_____	_____
Signature of Responsible Party	**Date of Responsible Party's Signature**	**Description of Authority to Act for the Individual (e.g., parent/guardian)**

A copy of this completed, signed and dated form must be given to the Individual or other signator.

Official Use Only		
_____	_____	_____
Received	**Processed By**	**Log #**