ONE TEAM HEALTH

HIPAA Authorization for
Release Health- Related Information
This authorization complies with the HIPAA Privacy Rule

Name of patient (Please Print)	Date of Birth
_____	_____
Name of unemancipated minor(s) (Please Print)	Date of Birth
_____	_____
_____	_____
_____	_____

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager, medical facility, insurance company, insurance support organization, or other health care provider that has provided payment, treatment or services to me on behalf or on the behalf of my unemancipated minor children ("Providers") to disclose the entire medical record and any other protected health information concerning me or my unemancipated minor children to One Team Health (hereafter referred to as the Company) and its agents, employees, and representatives. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, and psychotherapy notes.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information or that of my unemancipated minor children do not apply to this authorization and I instruct the Providers to release and disclose the entire medical record without restriction.

This protected health information is to be disclosed under this Authorization at my request, as permitted by § 164.508(c)(1)(iv) of the HIPAA (Health Insurance Portability and Accountability Act) Privacy Rule).

This authorization shall remain in force for 12 months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request for revocation to the Company at 2255 Sheppard Avenue East, Suite 415, Toronto, Ontario M2J 4Y1, Attention: HIPAA Privacy Official. Alternatively, I may revoke this authorization by sending a written revocation directly to the Providers. I understand that a revocation is not effective to the extent that any of the Providers has relied on this Authorization or to the extent that the Company has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal regulations governing privacy and confidentiality of health information in accordance with other applicable state and/or federal privacy laws and its own privacy policy.

I understand that the Providers may not refuse to provide treatment or payment for health care services because I refuse to sign this authorization. I further understand that if I refuse to sign this authorization to release my complete medical record or that of my unemancipated minor children, the Company may not be able to process my application, or if coverage has been issued may not be able to make any benefit payments. I acknowledge that I have received a copy of this authorization.

_____ _____
Signature of Primary Proposed Insured/Patient or Personal Representative Date

_____ _____
Signature of Secondary Proposed Insured/ Patient or Personal Representative Date

_____ _____
Description of Personal Representative's Authority or Relationship to Patient Date