KabaFusion
Patient-Focused Infusion Therapy

Authorization for Disclosure of Medical Information

I understand that this form is an authorization for the release and use of my personal medical information, and that it does not apply to uses or disclosures of my medical information for purposes of treatment, payment or health care operations. As indicated by my signature below, I agree as follows:

This authorization applies to the following medical records and information ("Records"):

_____

_____.

This authorization does not apply to any of the following medical information: (a) infection with or exposure to HIV, or the results of HIV tests, except if I am an injured worker claiming to be infected with or exposed to HIV through an exposure incident arising out of and in the course of employment; (b) my mental health, or (c) diagnosis and treatment for substance abuse. I agree to sign a separate authorization if it becomes necessary to disclose any information in any of these categories for the purposes set forth in this authorization.

This authorization applies to a request from the following person or entity:

_____

_____, which person or entity ☐ has ☐ or has not paid any compensation for the information.

This authorization applies to the following recipients who are authorized to received the Records:

_____

_____

This authorization applies to releases of my Records for the following purposes:

_____

_____,

and including but not limited to, for defending a claim, legal action or other proceeding brought by me, review by any governmental regulatory agency, and any other use reasonably related to these activities, and otherwise as may be required by law.

This authorization will remain in effect until _____, but not in any event exceeding two years from the date hereof.

I understand that: (a) I may inspect or copy the Records to be disclosed, (b) I may revoke this authorization by giving written notice of such revocation to your office to the

attention of the KabaFusion Privacy Officer, (c) any such revocation by me will not affect any actions that were already taken in reliance on this authorization, (e) the Records disclosed pursuant to this authorization may be further disclosed by the recipient, and no longer protected by HIPAA, and (e) I may refuse to sign this authorization and you will not condition my treatment on me providing this authorization.

ACCORDINGLY, as indicated by my signature set forth below, I acknowledge that I have read and understood this authorization, and that I hereby consent to such disclosures and uses as described herein. A photocopy of this form shall be as valid as the original. I acknowledge that I have the right to receive a copy of this authorization.

Date:_____ **Printed Name:** _____

Signature: _____
(patient or legal representative)

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