HIPAA AUTHORIZATION FORM
FOR USE AND DISCLOSURE OF HEALTH INFORMATION

The Fiscal Concierge, LLC is requesting your Authorization to use or disclose your health information. The following is information about the health information at issue, to whom it will be disclosed, how we will otherwise use or disclose your health information if you sign this form and your rights with regard to this Authorization. The next page of this form is the signature page that we request you sign to provide us your authorization to receive your health information as described in this form.

1. **Specific description of the health information:**
   Medical bills for health care I receive from My Health Care Providers (listed in Section 2 below) and such other information as necessary for The Fiscal Concierge, LLC to process and pay my medical bills.

2. **Persons/classes of persons who are authorized to use, or make the requested use or disclosure:**
   "My Health Care Providers" specified below –
   ____
   ____
   ____
   ____
   ____

3. **Persons/classes of persons/organizations authorized to receive the health information:**
   The Fiscal Concierge, LLC.

4. **Description of each purpose of the requested use or disclosure:**
   To process and pay my medical bills for health care I receive from My Health Care Providers.

5. **Expiration Date/Event:**
   This Authorization will expire when I am no longer a customer of The Fiscal Concierge, LLC.

6. **Right to Revoke:**
   I understand that I have the right to revoke this Authorization in writing at any time subject to the exceptions stated below. To revoke this Authorization, I understand that I must make my request in writing and clearly state that I am revoking this specific Authorization.

   Exceptions to Right of Revocation: I understand that my written revocation will not affect the ability of My Health Care Providers to continue to use or disclose my health information to the extent that it has already acted in reliance on this Authorization. For example, My Health Care Providers cannot rescind

disclosures they have already made, and may use my health information as necessary to bill and collect for services rendered. I also understand that my written revocation will not affect the ability of My Health Care Providers to continue to use or disclose my health information if I provided this Authorization as a condition to my obtaining insurance coverage, and other law provides the insurer with the right to contest a claim under the policy or to contest the policy itself.

7. **Prohibitions on Conditions:** I understand that my ability to receive treatment is not conditioned on my signing this Authorization.

8. **State Laws:** I understand that some jurisdictions may confer additional rights under State laws. I also understand that, if any provision of the Authorization is inconsistent with the laws of my State that give me additional rights, then the laws of my State will govern.

AUTHORIZATION SIGNATURE

Authorization Approval:

I hereby authorize the use or disclosure of the health information described in this Authorization. I understand that my health information may not be protected by federal privacy laws and may be subject to re-disclosure by the recipient person or organization unless other state or federal laws prohibit such re-disclosure.

Signature: ____
Print Name:

Address:

Date: ____________________________

Basis for legal authority to sign this Authorization if by a personal representative:

____
(parent, guardian, conservator, etc.)