



HIPAA Privacy Authorization Form

****Authorization for Use or Disclosure of Protected Health Information (Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)****

****1. Authorization****

In the event of an emergency, I authorize any and all emergency medical personnel to use and disclose the protected health information described below to RaceVermont.com.

****2. Effective Period****

This authorization for release of information covers the period from 12 am to 11:59 pm on _____, 2011.

****3. Extent of Authorization****

- a. I authorize the release of my complete health record
- b. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.
- c. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.
- d. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.
- e. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Signature _____ Date: _____

Printed Name _____