THE HARRISON GROUP, INC.

(HIPAA) Authorization Form

I, _____, give permission to The Harrison Group, Inc. to disclose the following protected health information to:

_____ _____

Authorized Person(s) Relationship *(broker/agent, spouse, parent, child, POA, legal guardian, etc.)*

Information to be disclosed (check all that apply):
☐ Debit Card Transactions information (including vendor names)
☐ Reimbursement Information
☐ Claims information (including providers and services rendered)
☐ Other: _____

This authorization expires on _____ (Month/Day/Year) .
Note: If date left blank, authorization will not expire until we receive written notification.

If the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be disclosed to other individuals or institutions and no longer protected by these regulations.

You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment or payment or your eligibility for benefits. You may inspect or copy the protected health information to be used or disclosed under this authorization. For protected health information created as part of a clinical trial, your right to access is suspended until the clinical trial is completed.

Finally, you may revoke this authorization in writing at any time by sending written notification to 3 Raymond Drive, Suite 201, Havertown, PA 19083. Your notice will not apply to actions taken by the requesting person/entity prior to the date they receive your written request to revoke authorization.

_____ _____

Signature of Participant Date

_____

Printed Name of Participant

_____

Employer Name

Please mail or fax this completed form to:
The Harrison Group, 3 Raymond Drive, Suite 201, Havertown, PA 19083
Fax: 610.853-9079
or e-mail to: service@theharrisongrouponline.com

Visit our website to access account information at: