AUTHORIZATION FOR THE USE AND DISCLOSURE OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION

Purpose: This form is used to request an individual's authorization for the use and disclosure of individually identifiable health information.

SECTION A: Individual Granting Authorization

Individual's Name: _____

Address: _____

Telephone: _____ E-mail: _____

SECTION B: Descriptions

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that the information I authorize a person or entity to receive may be re-disclosed and will no longer be protected by federal privacy regulations.

1. Specific description of information that may be used / disclosed:

2. The information will be used / disclosed for the following purpose(s):

3. Persons / organizations authorized to make the requested use or disclosure of the information:
   ☐ Plan ☐ CLIA Laboratory

4. Persons / organizations authorized to receive the information:

5. Will the persons / organizations authorized to use / disclose the information receive compensation for doing so?
   ☐ Yes ☐ No

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6. I understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment, payment for or coverage of services, or ability to obtain treatment, except as provided under numbers 7 and 8 on this form.

7. Unless the requested authorization is for the use or disclosure psychotherapy notes, if the purpose of this authorization is for the relevant Jackson Laboratory group health plan(s) to determine eligibility before enrollment and I refuse to sign this authorization, the plans reserve the right to deny enrollment or eligibility for benefits.

8. If the purpose of this authorization is to disclose health information to another party based on health care that is provided solely to obtain such information, and I refuse to sign this authorization, the relevant Jackson Laboratory group health plan reserves the right to deny that health care.

9. I understand that I may inspect or copy the information used or disclosed.

10. I understand that I may revoke this authorization at any time by giving written notice of my revocation to The Jackson Laboratory at the address listed below, except to the extent that:
    (a) action has been taken in reliance on this authorization; or
    (b) if this authorization is obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.

11. I understand that revocation of this authorization will *not* affect any action taken in reliance on this authorization before you received my written notice of revocation.

12. This authorization expires on: _____

Please submit this form to the HIPAA Privacy Officer at:

Sarah Wellings
600 Main Street
Bar Harbor, ME 04609
Sarah.Wellings@jax.org

SECTION C: Signature - You May Refuse to Sign This Authorization

I, _____, have had full opportunity to read and consider the contents of this authorization. I understand that, by signing this form, I am confirming my authorization that The Jackson Laboratory or the group health plan may use and/or disclose the protected health information described in this form for the purposes stated in this form.

Individual's Name: _____ **Date:** _____

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Individual's Signature: _____ **Date:** _____

YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION AFTER YOU SIGN IT

SECTION D: Revocation of Authorization

Authorization Revoked: _____

Date: _____