US Acute Care Solutions
4535 Dressler Rd. NW, Canton, OH 44718
Telephone: 1-855-687-0618
Fax: 330-492-8489

Authorization For Use and Disclosure of Protected Health Information 45 CFR §164.508

Federal and State Law, including the Health Insurance Portability and Accountability Act (HIPAA) requires health care providers to protect your health information. US Acute Care Solutions (USACS) provides billing and management services for affiliated or contracted healthcare providers, who provide acute medical services.

I authorize USACS and/or its employees or agents, including the treating physician or other health care providers, to release and disclose my Protected Health Information ("PHI") under the restrictions and conditions in this Authorization Form.

Section A: Patient Information

Complete all information requested in this section for the patient whose information will be released, disclosed, or verbally discussed with another individual or organization provided in Section B below.

Patient Name:
(First, Middle Initial, Last Name, Title [Sr., Jr., III.])

Date of Birth:

Telephone Number:

Street Address:

City:

State, ZIP:

Last 4 digits of Social Security Number:

Section B: Name of Individual / Organization Authorized to View, Receive, Or Verbally Discuss PHI

Please list the individual and/or organization that you are authorizing to view, receive, or verbally discuss your PHI. Organizations may include carriers, insurance companies, lawyers, law firms, etc.

Name of Individual/Organization:

Relationship to Patient:

Street Address:

Telephone Number:

City, State, ZIP:

Fax Number:

Section C: The following PHI may be released, disclosed, or verbally discussed with the individual/organization name in Section B above. Please check the applicable box.

◯ Billing records ◯ Both billing and medical records

◯ Medical records

Section D: Date(s) of Medical Treatment to be Released, Disclosed, or Verbally Discussed
Please check the applicable box and provide information.

◯ Date of medical treatment for illness, injury, or accident on: _____(date)

◯ Date of medical treatment for illness, injury, or accident from:
_____(date) to _____(date)

◯ At any and all times and dates treated

Section E: These records will be used/disclosed/for the purpose of:
Please select one purpose.

◯ Claim ◯ Continuing Care ◯ Legal ◯ Personal Use

◯ Other (specify) _____

Section F: Representative's Authority to Act on Behalf of Patient Named in Section A
Complete this section if you are a personal representative that is acting on behalf of the patient listed in Section A. You must include a copy of one of the following documents as proof of your legal representation and authority:

*Certificate of Guardianship documentation
*Medical Power of Attorney document
*Valid Health Care Proxy document

◯ Parent of minor child

◯ Medical Power of Attorney/representative (please provide documentation)

◯ Legal Guardian (please provide documentation)

◯ Health Care Surrogate (please provide documentation)

◯ Other - please specify (please provide documentation) _____

Representative's Name:
(First, Middle Initial, Last Name, Title [Sr., Jr., III.])

Relationship to Patient:

Full Street Address:

Telephone Number:

Signature

_____

Date

Section G: Statements of Understanding and Disclaimers

1. I understand that by signing this Authorization Form this may include disclosure of information relating to alcohol and drug use and/or abuse, mental health treatment (except psychotherapy notes), genetic testing information, pregnancy and contraceptive use, sexually transmitted diseases, and confidential AIDS/HIV related information. I give my consent for the disclosure of information.
2. I understand if the individual or organization that receives my Protected Health Information (PHI) may not be a health care provider or health plan covered by federal and state privacy regulations and the disclosed information may be redisclosed to a third party and that my PHI is no longer protected by those regulations. I release any and all parties permitted to disclose my PHI by this Authorization, and their employers and staff, from all liability arising from the disclosure of my PHI under this Authorization.
3. I understand that I have the right to revoke this Authorization, in writing, at any time by sending a written notice to: Privacy Officer, 4535 Dressler Rd. N.W., Canton, OH 44718. I understand that a revocation is not effective to the extent that action has already been taken in reliance upon this Authorization.
4. I understand that I may refuse to sign this Authorization and that my refusal to sign will not affect my ability to obtain treatment, payment or my eligibility for benefits.
5. Unless otherwise revoked, this authorization will expire 1 year from the date of the signature, unless an earlier date, event, or condition is noted here: _____

Section H: Signature/Date

Please read, complete, and review this Authorization Form in its entirety carefully before you sign.

It is my choice to sign this form and I do so voluntarily. I sign this Authorization under penalty of perjury and attest that the information contained in this Authorization is true and correct and may be relied upon by US Acute Care Solutions.

Signature of Patient:

_____

Printed Name (please write legibly)

_____

Date ☐

If you have any questions regarding this Form, please contact the USACS Patient Services Department at the telephone number provided below.

Please return this completed form to:

US Acute Care Solutions
Attention: Patient Services Department
4535 Dressler Rd. N.W.
Canton, Ohio 44718

Telephone: 1-855-687-0618
Fax: 330-492-8489