HIPAA COMPLIANT AUTHORIZATION FOR THERELEASE
OF PATIENT INFORMATION AND APPOINTMENT OF
AUTHORIZED REPRESENTATIVE
(Privacy Rule, 45 C.F.R. §164.508(c)(1)

SEND COMPLETED FORM TO:
Fax: **(860) 782-2091** or Email: **remede@priahealthcare.com**

Authorization for Release:

I, _____________________(Patient Name & DOB) hereby authorize _____________________(Practice Name) to release my Protected Health Information (PHI) as described below to ZOLL Respicardia, Inc. and PRIA HEALTHCARE MANAGEMENT ("PRIA") and their employees, business associates, agents, representatives, and designated third parties as requested by them for the purpose of and in connection with my precertification, appeal, grievance, Administrative Law Judge (ALJ) hearing, and/or independent review request of a denial of insurance benefits and/or coverage, including but not limited to:

MEDICAL RECORDS: Hospital records, chart and notes; laboratory records and reports; physical therapy records; doctors and nurse's notes; all correspondence of any kind; mental health, psychiatric and psychological records; substance abuse information; reports, tests and test results, x-ray films and reports; and, any and all other records which pertain to my medical care, treatment, history and prognosis.

INSURANCE/BILLING RECORDS: Any and all communications, notes, billing statements, claim forms, Explanation of Benefits, enrollment information, premium information or other benefits information or documents to/from insurance companies, self-insured plans, TPA's, claims administrators, Plan Sponsors, Plan Administrators, utilization review companies or other third-party payers involved with evaluating, adjusting, processing or paying my claim(s) for insurance benefits, whether pre-service or post-service in nature.

Additional Notices

I understand that signing this form is voluntary. I understand that my health information may be protected by HIPAA (45 CFR Parts 160 and 164), the Confidentiality of Alcohol and Drug Abuse Patient Records (42 CFR Part 2), and/or state laws. I understand that my health information may be subject to re-disclosure by the recipient and that if the organization or person authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by the federal privacy regulations. I understand that my records may contain information regarding my mental health, substance use or dependency, or sexuality, and also may contain confidential HIV/AIDS-related information. I further understand that by signing below, I am authorizing the release or exchange of these records to the parties named above. I also understand that my covered entity may not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this form. Any copies of this Authorization and Appointment of Representative shall be treated in all respects as though an original, including facsimile transmissions, thereof. I have been advised of my rights to receive a copy of this form.

Expiration: The above Authorization and the below Appointment of Representative will expire one year from the date entered below OR upon conclusion of my appeal process.

Revocation: I understand that I may revoke the above Authorization and/or the below Appointment of Representative at any time by notifying PRIA, in writing, to the e-mail address listed above. However, I understand that if I revoke the Authorization and/or Appointment of Representative, it will not have any effect on any actions PRIA and/or ZOLL Respicardia took before PRIA received the revocation.

Patient or Legal Representative Signature Authorizing Release: ____

Printed Name: ______________________________________ Date: ________________________

Appointment of Authorized Representative:

I hereby designate and appoint ZOLL Respicardia and PRIA and their employees/business associates to act as my authorized representative(s) with my insurance plan _______________ (Insurance Plan/Claims Admin), particularly with respect to my appeal of denied pre-service, concurrent or post-service claims, and to sign any future authorization or appeal forms on my behalf that are required by my insurance plan.

Eligibility Understanding

I understand that PRIA has not provided me with any guarantees or assurances that I am eligible for this appeal program or, in the event I am eligible, I acknowledge that I have NOT been promised any specific outcome to my appeal and that this appeal may ultimately denied or not processed by the payer. I further understand that this appeal program will not impact the personal financial responsibilities that I have with my health care provider, facility, and/or insurance plan.

I also understand that I may be asked to provide information, sign certain forms, obtain certain records or otherwise participate and assist PRIA during this appeal. I agree to respond to such requests in a timely fashion and understand that my failure to do so may negatively affect the outcome of my appeal. While I understand there are no costs for me to participate in this appeal program, some health care providers or other entities may require payment for copying medical records. Accordingly, I understand that if I want those records to be a part of my appeal package, I will be directly responsible for paying those providers.

Patient or Legal Representative Signature for Appointment of Representative: ______________________________

Legal Representative's Relationship to Patient ____________________________________

Printed Name: ______________________________________ Date: ________________________

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