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

SEND COMPLETED FORM TO:
Fax: **(860) 407-0359** or Email: **aimhigher@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 and PRIA HEALTHCARE MANAGEMENT ("PRIA") and their employees/business associates as requested by them for the purpose of and in connection with my precertification, appeal, grievance 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 be 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: _____**