Request for an Individual's Health Information from Hospital

I hereby authorize the use and/or disclosure of my individually identifiable health information as described below.

My address, phone number, insurance, diagnosis, and medical supply prescription information will be released by my physician to 180 Medical, Inc. 180 Medical, Inc. may use this information to contact my insurance company to facilitate insurance coverage and ensure the appropriate supplies are provided by 180 Medical, Inc.

I understand that the information used and/or disclosed may be subject to redisclosure by the person(s) or class of person(s) receiving it and no longer protected by the federal privacy regulations.

I hereby request access to the protected health information in my health record listed below (please check the requested information):

[ ] Entire Health Record [ ] Urine Culture lab reports for urinary tract infections and concurrent symptoms

[ ] Other ____

This authorization will expire one year from the date hereof, unless otherwise specified: ____________.

THE INFORMATION AUTHORIZED FOR RELEASE MAY INCLUDE INFORMATION, WHICH MAY INDICATE THE PRESENCE OF A COMMUNICABLE DISEASE, WHICH MAY INCLUDE, BUT IS NOT LIMITED TO, DISEASES SUCH AS HEPATITIS, SYPHILIS, GONORRHEA AND HUMAN IMMUNODEFICIENCY VIRUS ALSO KNOWN AS ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS).

I have been referred to HIPAA Section 164.520 "Notice of Privacy Practices for Protected Health Information" that contains a more complete description of the uses and disclosures of my medical information. I understand that I have the right to review that section before signing this authorization. I understand that I have the right to request additional restrictions on the disclosure of my information. I understand that I have the right to receive a copy of this authorization form.

I understand I may revoke this authorization by notifying my physician in writing of my desire to revoke it. However, I understand that if I revoke this authorization, it will not have any affect on actions previously taken in reliance on this authorization.

My physician will not condition my treatment, payment, or eligibility for benefits on whether I provide authorization for the requested use and/or disclosure.

______________________________ ______________________
Signature of Patient or Representative Date

______________________________ ______________________
Patient's Name Patient's Phone Number

______________________________ ______________________
Name of Personal Representative, If applicable Relationship to Patient