HIPAA AUTHORIZATION FORM

I, ____________________, give permission to ISMA Insurance Agency, Inc. (ISMAIA) to:

 use the following protected health information

 disclose the following protected health information to:

____
(Name of entity who will receive this information)

 disclose the following protected health information for marketing purposes that will result in remuneration for ISMAIA

Information to be disclosed (check all that apply):
 Medical Record from (insert date) _____________ to (insert date) __________________
 Entire Medical Record
 Other: ____
____
____

This protected health information is being used or disclosed for the following purpose(s):
____
____
____

This authorization expires on ____.
(insert date or event when authorization will expire)

1) If the person or entity receiving this information is not a health care provider or health plan covered by HIPAA, the information described above may be redisclosed to other individuals or institutions and therefore no longer protected by HIPAA.
2) You may refuse to sign this authorization. Your refusal to sign will not affect your payment, ability to obtain treatment, or eligibility for health plan benefits unless this authorization is requested prior to research related to treatment, enrollment in a health plan, or providing health care that is solely for the purpose of giving that information to a third party, such as to a court for a legal proceeding.
3) You may inspect or copy the protected health information to be used or disclosed under this authorization. For protected health information created as part of a clinical trial, your right to access is suspended until the clinical trial is completed.
4) You may revoke this authorization in writing at any time by sending a written notification to ISMAIA, 322 Canal Walk, Indianapolis, IN 46202, Attn: Privacy Officer. Your notice of revocation will not apply to actions taken by ISMAIA prior to the date of receipt of the notice.

Signature of Participant or Personal Representative Date

Printed Name of Participant or Personal Representative Description of Personal Representative's Authority