HIPAA AUTHORIZATION TO RELEASE HEALTH INFORMATION

DATE OF REQUEST: ______________

This HIPAA Authorization covers all protected health information (PHI) requested by me and maintained by the provider(s) identified below, including any such information created by such provider(s) during a period of up to 1 year after the Date of Request written above, *UNLESS* this HIPAA Authorization is revoked by me or the following box is checked and a different date range is provided here: ❒ only PHI created/dated between ___/___/___and___/___/

1. PURPOSE OF REQUEST & RECIPIENT

This request is made at the request of ❒ the Individual ❒ the Individual's Legal Representative ❒ Other: ________________________
for the purpose of disclosing the Information identified below to **ZWEENA LLC,** a PHR vendor with offices located at 57 Hamilton Avenue, Suite 302, Hopewell, NJ 08525 **,** so that Zweena, LLC can collect and maintain such Information for and on behalf of the Individual.

2. INDIVIDUAL'S INFORMATION

Name:	Home Address:	
DOB:	Phone #:	E-mail:

3. DISCLOSING PARTIES

I hereby authorize the following **parties** to disclose the identified below to Zweena LLC (*check only one*) **:**

❒ **ANY & ALL** health care providers (the "class") that have created or maintain Information about me

❒ *ONLY* the following provider(s):

Provider's Entity Name	Primary Contact Name:	Phone:
1.		
2.		
3.		

4. INFORMATION AUTHORIZED FOR RELEASE

I hereby authorize the following **protected health information ("Information")** to be disclosed to Zweena LLC (*check only one*) **:**

❒ **My Entire Medical Record**

❒ *ONLY* the following Information (*please describe*):

5. INFORMATION REQUIRING SPECIFIC CONSENT FOR RELEASE

The following categories of Information **should NOT** be disclosed *unless* my signed initials appear next to the category indicating that I specifically consent to the release of such sensitive information pursuant to this Authorization.

____ 42 CFR Part 2 Records
____ HIV/AIDS-related information
____ Psychotherapy Notes
____ Emancipated Minor's Records
____ Psychiatric admits from ED
____ Venereal Diseases (STDs)
____Genetic Information

I understand that the terms of this Authorization are governed by the Health Insurance Portability and Accountability Act of 1996, and its implementing regulations, as may be amended from time to time ("HIPAA"). I understand that I have the right to revoke this Authorization, at any time prior to the Disclosing Party taking action in reliance on this Authorization, and provided that the revocation is in writing. I understand that any revocation must include my name, address, telephone number, date of this Authorization and my signature. I understand that additional information relating to the exceptions to the right to revoke and a description of how I may revoke this Authorization is set forth in my provider's Notice of Privacy Practices. I understand that in the alternative I may send my revocation to **ZWEENA** online at **support@zweenahealth.com** or by fax to **866.560.8543,** and Zweena will ensure that my provider receives my revocation in a timely manner. I understand that I am not required to sign this Authorization and that my provider cannot condition treatment on my execution of this Authorization. I understand that once my Information is disclosed pursuant to this Authorization, it may be re-disclosed by the recipient listed above and, in that case, many no longer be protected by HIPAA. This Authorization EXPIRES automatically 1 year from the Date of Request written above.

I HEREBY ACKNOWLEDGE THAT A COPY OF THIS AUTHORIZATION HAS BEEN PROVIDED TO ME.

____ ____/_____/_____

Signature of Individual (*or Legal Representative*) Date

Authority of Legal Rep: ❒ Court-Appointed Guardian ❒ Parent of Minor ❒ Power of Attorney ❒ Other (*specify*): _______________________

Last Modified 01/31/2013

Fax to 866.560.8543
Questions? Call 877.848.4248
www.zweenahealth.com