ACCESS PLANS USA
AUTHORIZATION TO RELEASE PROTECTED HEALTH RECORDS

I ________________________________ who resides at ________________________________

in the city of ______________________ in the state of ____________ hereby authorize:

Name: USA Healthcare Savings

Address: 4929 W. Royal Lane

City, St., Zip: Irving, Texas 75063

to disclose the following specific health information by ☐ mail or ☐ fax or ☐ e-mail to:

Name: ________________________________
(PHYSICIAN, HOSPITAL, CLINIC, OR OTHER HEALTHCARE PROVIDER, HEALTHPLAN, THIRD PARTY ADMIN, OTHER PAYOR OR OTHER PARTY)

Address: ________________________________

City, St., Zip: ________________________________

from the Health Records of:

Name: ________________________________
(NAME OF INDIVIDUAL WHOSE HEALTH OR PRESCRIPTION DRUG RECORD IS BEING DISCLOSED)

Address: ________________________________

City, St., Zip: ________________________________

For the purpose of: ________________________________

My authorization extends only to those data elements/documents initialed below:

_______ Statements of charges or payments

_______ Record of visits (all visits)

_______ Record of visit for a specific date or dates. Specific dates include or are limited to: __________

_______ Copies of records or reports provided to the above named (i.e. hospital, lab, clinic, etc)

_______ Progress Notes

_______ Photographs, videotapes, digital or other images.

_______ Discharge Summary

_______ History and Physical Examinations

_______ Consultation Reports

_______ All of the above

_______ Other (Must be specific) ________________________________

_______ Mental Health and/or alcohol and drug abuse treatment

_______ AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus)

_______ Hepatitis Information

This authorization is given freely with the understanding that:

1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law.

2. A photocopy or fax of this authorization is as valid as this original.

3. I may revoke this authorization at any time, except where information has already been released. This authorization is valid for a one year period from the date it is signed, or sooner if noted below. I understand the revocation must be in writing and that the revocation form is available upon request from Member Services.

4. Access Plans USA, Inc, its employees, officers, and directors are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

5. Treatment, payment, enrollment or eligibility for benefits may not be conditioned upon obtaining this Authorization.

6. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and is no longer protected.

(MEMBER'S NAME PRINTED)	DATE
MEMBER'S SIGNATURE (OR GUARDIAN, IF A MINOR)	EXPIRATION DATE (IF OTHER THAN ONE YEAR FROM DATE ABOVE)
SOCIAL SECURITY NUMBER (FOR IDENTIFICATION PURPOSES ONLY)	
WITNESS	DATE