

Authorization For the Use or Disclosure of Protected Health Information

I hereby authorize _____ to use or disclose the following information from the health records of the individual whose name is described below.

Please print
Patient Name: _____ Date of Birth: _____
Address: _____
(city) (state) (zip) _____
Phone Number _____ Social Security # _____

I authorize _____ to release medical, mental, alcohol and/or drug abuse, HIV testing, AIDS, eating disorders or any other medical information of a sensitive nature to the following individuals or organization(s):

Name: Network Credit Services, Inc.
Address: Brandon, Fl 33511
(city) (state) (zip)

The information for which I am authorizing disclosure will be used for the following purpose:

Description: Application of a mortgage loan
Dates of Service to be Released: _____

The type of information to be used or disclosed is as follows (check the appropriate boxes and include other information where indicated)

Abstract Discharge Summary
 History & Physical Reports Operative Reports
 Consultation Reports Progress Notes
 Lab Results/X-ray & Imaging Billing, Payment & Balance Information
 Other: (please describe) Name of Facility where treatment was received

I understand that if the organization authorized to receive the information is not a health plan or healthcare provider, the released information may no longer be protected by Federal privacy regulations. I understand that I need not sign this authorization to ensure treatment. This authorization shall remain valid for 6 months from the date signed below.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the department or facility listed on the authorization. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

Signed: _____ Date: _____
Patient or Authorized Person () Parent () Legal Guardian () Executor () Power of Attorney

Witness _____ Date: _____

REVOCACTION SECTION – I hereby revoke this authorization.
Signed _____ Date: _____