HIPAA Release Authorization

I, ____________________________, DOB ___/___/___, gives permission to _________________________________ (Agency Name) and any employee of the firm, permission to receive any medical information (whether written, verbal, or via electronic transmittals) on my behalf regarding any of the following:

Status on all new or existing claims
Medical Records
EOB's, Billing Records
Treatment Records
Diagnostic Records
Other:____

This protected health information is being used or disclosed for the following purposes:

to support and help in the processing of a private supplemental insurance claim through Bay Bridge Administrators, LLC and/or________________________________ (Agency Name).

If the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be disclosed to other individuals or institutions and no longer protected by these regulations.

You may revoke this authorization in writing at any time by sending written notification to:

Agency Name: ____
Agency Address: ____
Agency City, State, Zip Code: ____

Your notice will not apply to actions taken by the requesting person/entity prior to the date they receive your written request to revoke authorization.

____ ________________________
Signature of Participant or Personal Representative Date

____
Printed Name of Participant or Personal Representative

This form does not guarantee the payment/and or approval of any new or pending claim.