



## MEDICAL AUTHORIZATION FORM

To: York Insurance Services Group, Inc.  
 P.O. Box 619058  
 Roseville, CA 95661-9058

I, \_\_\_\_\_ hereby authorize the following medical providers (medical provider is defined as any acupuncturist, clinic, chiropractor, physical therapy provider, primary physician, or specialist who has administered medical treatment to me) to disclose their entire medical file and any other protected health information concerning me to YORK INSURANCE SERVICES GROUP, INC. and its agents, employees and representatives. The protected health information to be disclosed includes medical records; doctors notes; laboratory records/reports; diagnostic test reports/films; photographs; bill/statement of charges; and, all documentation pertaining to history, examination, diagnosis, condition, etiology, prognosis, treatment and care.

<b>Faculty/Physician Name/s</b>			
<b>Address</b>			
<b>Phone Number</b>			
<b>First Treatment Date</b>			
<b>Last Treatment Date</b>			

This authorization also includes disclosure of information on the diagnosis and treatment of:

	Yes	No
Mental illness including psychiatric/psychological treatment	___	___
Alcohol, drugs and tobacco	___	___
HIV infection and sexually transmitted diseases	___	___

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct My Providers to release and disclose my entire medical record without restriction except those outlined above. This protected health information is to be disclosed under this authorization at my request, as permitted by 164.508©(1)(IV) of the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule.

This authorization shall remain in force for 24 months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this Authorization in writing, at any time, by sending a written request for revocation to YORK INSURANCE SERVICES GROUP, INC. or by sending a written revocation directly to My Providers. I further understand that a revocation is not effective to the extent that any of My Providers has relied on this Authorization. I understand that any information disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal regulations governing privacy and confidentiality of health information (such as the HIPAA Privacy Rule). However, YORK INSURANCE SERVICES GROUP, INC. agrees to protect the privacy of health information in accordance with other applicable state and/or federal privacy laws and its own privacy policy.

I understand that My Provider may not refuse to provide treatment or payment for health care because I refused to sign this Authorization. I acknowledge that I have received a copy of this Authorization.

\_\_\_\_\_  
 Signature \_\_\_\_\_ Print Name \_\_\_\_\_ Date

\_\_\_\_\_  
 Date of Birth \_\_\_\_\_ Social Security Number

*This authorization complies with HIPAA Privacy Rule*

(Medical Info Release Authorization)