AUTHORIZATION FOR USE OR DISCLOSURE OF "PROTECTED HEALTH INFORMATION"

PATIENT'S NAME: ____

Authorization initiated by: ☐ Patient ☐ **QUE Financial**

I understand that "Protected Health Information" about me is information that may identify me and relates to my past, present and future related health care services. I authorize the use and disclosure of Protected Health Information about me as described below:

1. Description of purpose of use and disclosure:

   ☐ At my request, I elect not to provide a statement of the purpose of use and disclosure. *(Note: This box may be checked only if the patient initiates this authorization)*

   ☐ My Protected Health Information may be used and disclosed for the following purposes:
   ☐ Debt reduction and/or financial planning/counseling activities
   ☐ Other: ____
   ____
   ____
   ____

2. Person(s) or class of persons authorized to use, disclose or receive the information:

   ☐ **QUE Financial**
   ☐ Employee/agents of the following entity: ____________________________
   ☐ Others, as follows: ____
   ____

3. Description of the information to be used and disclosed: ____________________
   ____

4. This authorization will expire upon the following date or event: ______________
   ____

5. I request that the following restrictions(s) be observed with respect to information disclosed pursuant to this authorization: ____
   ____
   ____
   ____

6. I understand that if the person or entity that receives the information is not a health care provider of a health plan covered by federal privacy regulations, the information described above may be re-disclosed.

7. I understand that this authorization is voluntary and that I may refuse to sign this authorization. I understand that **QUE Financial** may not condition treatment, payment, enrollment or eligibility for benefits on whether or not I sign this authorization. I understand that I may inspect or copy any information used or disclosed under this authorization.

8. I understand that I may revoke this authorization at anytime except to the extent that action had been taken in reliance on this authorization. I further understand that to revoke this authorization, I must deliver a writing to **QUE Financial's** HIPAA Compliance Liaison at the following address:

HIPAA Compliance Liaison
QUE Financial Serviceware Technologies
P.O. Box 990003
8948 W. Barnes
Boise, Idaho 83799-0003

This authorization will remain in effect until it expires or **QUE Financial** receives my written revocation.

______________________________ ______________________

Signature of Patient or Responsible Party Date

____

Name of Responsible Party (If applicable)

Responsible party's relationship to patient and basis for authority to sign on behalf of patient.

____

____