INDIVIDUALS INVOLVED IN PAYMENT FOR HEALTHCARE

The Health Insurance Portability and Accountability Act (HIPAA) protects the patient’s right to privacy. In order to comply with these federal privacy laws, healthcare facilities (covered entities) may provide limited information about your treatment to individuals who are involved in payment decisions unless you object to sharing this information.

As a covered entity, defined by HIPAA, we ask that you list the individuals you wish to authorize to receive your health information for this limited purpose. Please provide the full names of these individuals in the lines below and their relationship to you. You do not need to list yourself if you are the patient.

I authorize the following individuals to receive information related to my treatment in order to assist in payment decisions or make payments or my behalf.

<table>
<thead>
<tr>
<th>Individual’s Full Name (Please Print)</th>
<th>Relationship to Patient</th>
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The information will be presumed valid and the covered entity may rely on it until you have notified the covered entity in writing of any changes to this form.

____________________________________ ___________________________________
Full Patient Name (Printed)    Legal Representative (Printed) if applicable

____________________________________
Patient or Legal Representative (Signature)  Date

____________________________________
Patient Date of Birth     MR#/PUID

Form created by Purdue University HIPAA Privacy Office