HIPAA/CMIA AUTHORIZATION
PENINSULA PLUG
HIPAA/CMIA AUTHORIZATION

Member Name: _____

Date of Birth: _____

I am either the Patient named above or the Patient's legally authorized representative.

This release authority applies to any information governed by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 42 U.S.C. § 1320(d) and 45 C.F.R. § 160-164, and/or information governed by the California

Confidentiality of Medical Information Act ("CMIA") Cal. Civ. Code § 56-56.37. Specifically, this release authority complies with the valid authorization requirements of 45 C.F.R. § 164.508(c).

Pursuant to HIPAA and/or CMIA, I authorize and direct any physician, healthcare professional, dentist, health plan, hospital, clinic, laboratory, pharmacy, or other covered health care provider, any insurance company, and the Medical Information Bureau, Inc., or other health care clearinghouse that has provided treatment or services to me or that has paid for or is seeking payment from me for such services, to give, disclose, and release, without restriction, all of my individually identifiable health information and medical records regarding any past, present, or future medical or mental health condition, to include all information relating to the diagnosis and treatment of sexually transmitted diseases, mental illness, and drug or alcohol abuse to PENINSULA PLUG.

The purposes of the usage and disclosure shall include determinations regarding my qualification to use medical marijuana and monitoring my health care to protect my legal rights where I reside.

I understand that, with certain exceptions, I have the right to revoke this Authorization at any time. If I want to revoke this Authorization, I must do so in writing. The procedure for how I may revoke this Authorization, as well as the exceptions to my right to revoke will be performed in accordance with applicable federal law and any applicable policy of my health care provider.

I understand that I may refuse to sign this Authorization. I also understand that my health care provider cannot deny or refuse to provide treatment, payment, and enrollment in a health plan, or eligibility of benefits if I refuse to sign this Authorization.

I understand that, once information is disclosed pursuant to this Authorization, it is possible that it will no longer be protected by applicable federal medical privacy law and could be re-disclosed by the person or agency that receives it; however, I do not authorize such secondary disclosure.

The authority given to the persons or parties named above shall supersede any agreement that I may have made with my health care providers to restrict access to or disclosure of my individually identifiable health information. The authority given has no expiration date and shall expire only in the event that I revoke the authority in writing and deliver it to my health care provider.

I have read and understand the information in this Authorization form.

Signature of Patient:_____

Date: _____