UNITY HEALTHCARE, LLC
HIPAA AUTHORIZATION
DISCLOSURES TO FAMILY AND/OR FRIENDS

Patient Name: _____ **Patient DOB:**_____

1. By signing below, I hereby authorize the following health information to be used and disclosed as described in this Authorization: _____ ("Protected Health Information").
2. The specific person or class of persons who are authorized to use or disclose my Protected Health Information are as follows: Unity Healthcare, LLC

   _____ Division

   plus all my other Unity Healthcare providers and professionals ("Unity").
3. The persons or class of persons to whom Unity, a Covered Entity, may make the use or disclosure of my Protected Health Information are as follows: _____; _____; _____.
4. I understand that the purpose of the use or disclosure is: at my request, to enable them to be aware of and participate in of my care and treatment provided by Unity.
5. I understand that Unity will not condition treatment, payment, enrollment in a health plan or eligibility for benefits on the provision of this Authorization to Unity.
6. I understand that the information to be disclosed may contain information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), behavioral or mental health services, hepatitis, tuberculosis, and treatment for alcohol and drug abuse.

   No, I do not authorize this type of disclosure _____Initial
7. This Authorization shall expire: one (1) year from the date signed below.
8. I understand that I have the right to revoke this Authorization by contacting Unity, if the revocation is in writing, except to the extent that Unity has taken action in reliance upon this Authorization.
9. I understand that my Protected Health Information that is used or disclosed under this Authorization may be subject to re-disclosure by the recipient, and the privacy of my Protected Health Information may no longer be protected by the law.
10. I understand that the use or disclosure of my Protected Health Information by Unity will not result in direct or indirect remuneration to Unity from a third party.

    By signing this Authorization, I acknowledge that I have read and understand this Authorization. Further, I authorize the use or disclosure of my Protected Health Information in accordance with the terms of this Authorization.

_____
Patient Signature

_____
Date