FORMULARIO DE LIBERACIÓN DE HIPAA PARA PROCEDIMIENTOS DE DISTRIBUCIÓN DE CONFIANZA DE NON-NAS PI Y EXPLINACÍON

El formulario adjunto se refiere a Health Insurance Portability and Accountability act of 1996 (HIPAA).

La Regla de Privacidad también contiene estándares para los derechos de las personas a comprender y controlar cómo se usa su información de salud. Un objetivo importante de la Regla de Privacidad es asegurarse de que la información de salud de las personas esté debidamente protegida al tiempo que permite el flujo de información de salud necesaria para proporcionar y promover atención médica de alta calidad, y para proteger la salud y el bienestar del público. La Regla de Privacidad permite usos importantes de la información al tiempo que protege la privacidad de las personas que buscan atención y curación.

Tenga en cuenta que esto solo se utilizará para resolver gravámenes médicos con respecto a su reclamo de NON- NAS opioide Mallinckrodt y no por ningún otro motivo. En cualquier momento, tiene derecho a revocar esta autorización. Entiendo que autorizar la divulgación de esta información de salud es voluntario. Puedo negarme a firmar esta autorización y renunciar a una recuperación bajo los Procedimientos de Distribución del Fideicomiso de Lesiones Personales de Mallinckrodt Opioid NON-NAS. Entiendo que ninguna organización puede condicionar el tratamiento, el pago, la inscripción o la elegibilidad para los beneficios a mi firma de esta autorización. Entiendo que puedo inspeccionar o copiar la información que se utilizará o divulgará, según lo dispuesto en CFR 1634.524.

Entiendo que cualquier divulgación de información conlleva la posibilidad de una redivulgación no autorizada y la información puede no estar protegida por las reglas federales de confidencialidad o HIPAA. Si tengo preguntas sobre la divulgación de mi información de salud, puedo comunicarme con las partes mencionadas anteriormente en la sección # 4. Asegúrese de firmar el formulario adjunto.

HIPAA RELEASE FORM FOR
NON-NAS PI TRUST DISTRIBUTION PROCEDURES

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Claimant Name:_____ **Date:**_____

Date of Birth:_____ **Soc. Sec. No.**_____

1. The following individuals or organizations are authorized to disclose my health records to the parties specified below in section #4:

_____
_____
_____
_____
_____

(Note: Please list the names of your medical care providers and your health insurance providers that may have records relevant to the resolution of your PI Claim. If you are unsure of the exact legal name of your medical providers and health insurance providers, you can leave this blank, and we will complete it for you with the understanding that you authorize all relevant parties):

2. The type and amount of information to be used or discloses is as follows:

The entire record, including but not limited to: any and all medical records, mental health records, psychological records, psychiatric records, problem lists, medication lists, lists of allergies, immunization records, history and physicals, discharge summaries, laboratory results, x-ray and imaging reports, medical images of any kind, video tapes, photographs, consultation reports, correspondence, itemized invoices and billing information, and information pertaining to Medicaid or Medicare eligibility and all payments made by those agencies, for the following dates:

Dates of Services - From:_____ To: _____

(Note: List the date range for which the medical providers and insurance companies above may have records relevant to the resolution of your PI Claim. If you are unsure of the exact dates, then leave this blank, and we will complete this section for you with the understanding that you authorize all relevant date ranges).

3. I understand that the information in my health records may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, as well as treatment for alcohol and drug abuse.

4. The health information may be disclosed to and used by the following individual and/or organization:

    a. Mallinckrodt Opioid Personal Injury Trust
    b. Edgar C. Gentle, III., of Gentle, Turner & Benson, LLC, as the Trustee and Claims Administrator of the Mallinckrodt Opioid Personal Injury Trust
    c. MASSIVE: Medical and Subrogation Specialists

5. I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to the health information management department. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire 10 years after the date that I sign it.

6. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization and forego a recovery under the Mallinckrodt Opioid Non-NAS Personal Injury Trust Distribution Procedures. I understand that no organization may condition treatment, payment, enrollment, or eligibility for benefits on my signing of this authorization. I understand I may inspect or copy the information to be used or disclosed, as provided in CFR 1634.524. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules or HIPAA. If I have questions about disclosure of my health information, I can contact the parties listed above in section #4.

_____ _____

Patient or Legal Representative Date

_____

Relationship to Patient (If signed by Legal Representative)