

APRIA HEALTHCARE

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

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Individual's Name: \_\_\_\_\_  
Last First Middle

Home Address: \_\_\_\_\_

Home Telephone: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

DESCRIBE INFORMATION TO BE DISCLOSED. PLEASE BE SPECIFIC: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**MY HIGHLY CONFIDENTIAL INFORMATION:**  
By signing my name next to a category of highly confidential information listed below, I specifically authorize the use and/or disclosure of the type of highly confidential information indicated next to my signature, if any such information will be used or disclosed pursuant to this Authorization:

- Information about a Mental Illness or Developmental Disability \_\_\_\_\_
- Information about HIV/AIDS Testing or Treatment \_\_\_\_\_  
(including the fact that an HIV test was ordered, performed or reported, regardless of the results of such tests)
- Information about Venereal Disease \_\_\_\_\_
- Information about Substance (i.e., alcohol or drug) Abuse \_\_\_\_\_
- Information about Abuse of an Adult with a Disability \_\_\_\_\_
- Information about Sexual Assault \_\_\_\_\_
- Information about Child Abuse and Neglect \_\_\_\_\_
- Information about Genetic Testing \_\_\_\_\_
- Other state designated Highly Confidential Information \_\_\_\_\_

RECIPIENT: Name of person or class of persons to whom Apria Healthcare may disclose my health information: \_\_\_\_\_

Address of the recipient or where my health information should be delivered: \_\_\_\_\_

TERM: This Authorization will remain in effect:  
 From the date of this Authorization until the \_\_\_ day of \_\_\_\_, 20\_\_.  
 Until Apria Healthcare fulfills this request.  
 Until the following event occurs: \_\_\_\_\_

Other: *Note: If treatment is related to the participation in a research study, an expiration date/event of "none" may be used.* \_\_\_\_\_

Provide the patient with a copy of this signed Authorization.

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PURPOSE: I authorize Apria Healthcare to use or disclose my health information (including the highly confidential information I selected above, if any) during the term of this Authorization for the following specific purpose(s): Note: "At the request of the patient" is sufficient if the patient is initiating this Authorization.

Four horizontal lines for writing the specific purpose(s).

REDISCLASURE: I understand that once Apria Healthcare discloses my health information to the recipient, Apria Healthcare cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

MARKETING: I understand that Apria Healthcare may, directly or indirectly, receive remuneration from a third party in connection with the use or disclosure of my health information.

REFUSAL TO SIGN: I understand that I may refuse to sign this Authorization for any reason and that such refusal will not affect the commencement, continuation or quality of my treatment at Apria Healthcare; except, however, that Apria Healthcare may refuse to treat me if I do not sign this Authorization if my treatment at Apria Healthcare is for the sole purpose of creating health information for disclosure to the recipient identified in this Authorization or if my treatment is related to my participation in a research study.

REVOCAATION: I understand that I may revoke, at any time, this Authorization for any reason by providing an Apria Healthcare representative with a written revocation, unless Apria Healthcare has already acted in reliance upon this Authorization or this Authorization was obtained as a condition of obtaining insurance coverage.

I understand that this Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation to a representative of Apria Healthcare.

I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my health information. By my signature below, I hereby, knowingly and voluntarily, authorize Apria Healthcare to use or disclose my health information in the manner described above and hereby acknowledge receipt of a copy of this signed Authorization.

Signature of Patient Date

If the patient is a minor or is otherwise unable to sign this Authorization, obtain the following signatures:

Signature of Personal Representative Description of Authority Date

Provide the patient with a copy of this signed Authorization