AUTHORIZATION FOR DISCLOSURE OF PERSONAL HEALTH INFORMATION

The Morlock Foundation, Inc. CLIENT #_____

Instructions: By completing this form, I do hereby authorize my health care providers and their applicable business associates to disclose the following Protected Health Information ("PHI") pertaining to me: enrollment, claims, payment and managed care information, to Health Advocate, Inc. for the purpose of administering the Health Advocate program, including but not limited to assistance in my quest to obtain health care services and approval or payment for health care services. I understand I may exclude the release of certain information under this agreement. Accordingly, I wish to exclude the

following information _____

I understand I am not required to authorize Health Advocate to have access to my PHI and that I can refuse to sign this authorization. I understand that by refusing to sign this authorization I will not be able to participate in the services offered by Health Advocate.

Name: _____

(Last) (First) (MI)

Address: _____

Street (Apt #) City State Zip

Home Telephone: (____) _____ Cell Telephone: (____) _____

Health Insurance Carrier: _____ Group # _____

Plan Type: HMO POS PPO INDEMNITY Member #: _____

I understand that Health Advocate provides administrative and Informational services only and does not provide health insurance or medical services nor does it recommend treatment. Consequently, independent health care practitioners, who are not employees or agents of Health Advocates, will provide all my medical services.

I understand that I may revoke this authorization at any time by giving written notice of my revocation to Health Advocate's Privacy Officer at the above address. I understand that revocation of this authorization will not affect any action that Health Advocate or other parties took in reliance on this authorization before it received my written notice of revocation.

I understand that unless otherwise revoked, this authorization will commence on the date indicated below and will expire on the following date, event or circumstance:

If I fail to specify, this authorization will expire in 12 months.

I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and that the information may not be protected by federal health information privacy laws.

AUTHORIZATION FOR DISCLOSURE OF PERSONAL HEALTH INFORMATION

The Morlock Foundation, Inc. CLIENT #_____

As required by the Health Insurance Portability and Accountability Act of 1996. The Morlock Foundation, Inc. (TMF) may not use or disclose your clinical/health information except as provided in our Notice of Privacy Practises without your authorization. The Morlock Foundation, Inc. has generated as well as the information it has received from other treating providers involved in your care. Your signature on this form indicates that you are giving permission for the uses and disclosures of protected personal information described herein. You may revoke this authorization at any time by signing and dating the revocation section on your copy of this form and returning it to The Morlock Foundation, Inc.

AUTHORIZATION SECTION

I, _____ (print name), the undersigned, hereby authorize the disclosure of the following information DOB: _____ Name if not self _____ (Please specify the type of information or list multiple numbered types of information.) [ ]Academic [ ]School Attendance [ ] Psychological/Social Work/Psychiatrist [ ] Health [ ] Test Results [ ]Hospital [ ]Medical [ ]Other: _____

Address and Phone (requesting from)
Name: _____
Address(Street): _____
City/State/Zip: _____
Phone: _____ Fax: _____
Email: _____

Information should be sent to:
Morlock Foundation, Inc., 140 Genesee Street, Lockport, NY 14094 or by HIPAA compliant fax of 716-249-3388

I authorize TMF representatives who are involved in my care to make these disclosures.
I understand that I may revoke this authorization at any time by signing the revocation sections of my copy of this form and returning it to The Morlock Foundation, Inc. I further understand that any such revocation does not apply to the extent that persons authorized to use or disclose my clinical/health information have already acted in reliance on this authorization.
I understand that I am under no obligation to sign this authorization. I further understand that my ability to obtain or receive services from TMF will not depend in any way on whether I sign this authorization form or not. I understand that it may limit my ability to receive certain services.

Signature: _____ Date: _____

_____ Date: _____

(Personal Representative: Include a description of authority to act for the patient)
YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION FORM AFTER YOU SIGN IT.