9435 45th Ave. SW
Seattle, WA 98136

Website http://www.all4cure.com
Email records@all4cure.com
Phone (206) 412-1787
Fax (206) 267-0104

HIPAA Privacy Authorization Form

**Authorization for Use or Disclosure of Protected Health Information
(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)**

1. Authorization

I authorize ____ ____________ (healthcare provider) to use and disclose the protected health information described below to Dr. Anthony Blau, All4Cure Inc.

Please mail, email or fax the records to:

Mail	Email	Fax
ATTN: Dr. Anthony Blau All4Cure, Inc. 9435 45th Ave. SW Seattle, WA 98136	records@all4cure.com	(206) 267-0104

2. Effective Period

This authorization for release of information covers the period of healthcare from:

a. ☐ _______to _______.

OR

b. ☐ all past, present, and future periods.

3. Extent of Authorization

a. ☐ I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).

OR

b. ☐ I authorize the release of my complete health record with the exception of the following information:

- ☐ Mental health records
- ☐ Communicable diseases (including HIV and AIDS)
- ☐ Alcohol/drug abuse treatment
- ☐ Results of all genetic tests
- ☐ Other (please specify): _________________

4. Your information will be publicly viewable to anyone on the Service, including individuals, clinicians, caregivers, and researchers. Your information may be used in the future for research. Your information is still protected by All4Cure's privacy policy (https://www.all4cure.com/privacy).

5. This authorization shall be in force and effect indefinitely.

6. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

7. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

8. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

9. I understand that I am requesting these records for my own use.

10. I understand that I can withdraw consent at any time as described in All4Cure's Terms of Service (https://www.all4cure.com/terms-of-use) and Privacy Policy (https://www.all4cure.com/privacy).

Signature of patient (or personal representative): ____

Name of patient (or personal representative):____

Date of Birth: __________________________

Email Address: ________________________ Phone Number: _____________________________

Date: _______________________________

Last updated: 5/9/2019