Personal Accounting Services, Inc.
An AssuranceSD family company

PARTICIPANT AUTHORIZATION FOR RELEASE OF NONMEDICAL INFORMATION

(This is a Two-Part Release – Both Forms Must be Executed)

(NAME) (DATE OF BIRTH)

I hereby authorize Personal Accounting Services to release, receive, information to or from Contract\Waiver Agencies, Government & Tax Agencies, Authorized Representative (legal or non-legal), Staffing Agencies, Support Staff and Insurance Companies.

I have selected **Personal Accounting Services as my Representative**. To manage, release and receive information on my behalf from financial intuition's, Human Health Services (Department of Human Services), utilities companies, Employer's and any other entity needed to coordinate, including the setup of accounts needed to support all services including Employer's EIN and a Workers Compensation Policy.

I hereby authorize Personal Accounting Services to transport my Personal Health Information to and from meetings, offices, and entities needing to coordinate my supports and services.

I hereby authorize Personal Accounting Services to disclose my Personal Health Information for payment.

I hereby authorize Personal Accounting Services to set-up and maintain the necessary accounts on my behalf. This may include the authorizing use of the Internet for setup and making of payments.

2. Discloser may consist of the following but not limited to:
Name, address, phone number, Authorized Representative (legal or non-legal), contact person, name and number of Care Coordinator, Social Security number, EIN and benefit information, Date of Birth, authorized services and accounts balances.

3. Purpose or need for disclosure:
Enrollment and continue service of an Individuals account. Which includes but not limited to the setup of accounts obtaining EIN numbers and Workers Compensation Policies, making vendor payments, complete application for food stamps & Medicaid or any other entitlements. Communicate with utility companies, landlords, physicians, pharmacies, IRS and Social Security Administration. Collaborate with other professionals, and communicate with agencies or individual(s) involved in your supports and services.

This authorization will remain in effect until services with Personal Accounting Services have been terminated. Once Personal Accounting Services receives the written termination this authorization will be valid 30 days following the termination date. The 30 days will allow the transfer or closing of your accounts.

Names and signatures must be legible.

SIGNATURE OF INDIVIDUAL or Representative	Relationship	DATE
WITNESS #1 (Print and sign name)	Relationship	DATE
WITNESS #2 (Print and sign name)	Relationship	DATE

This release must be signed by at least one witness. Two witnesses are required if this statement has been signed by a mark (X).

PARTICIPANT AUTHORIZATION FOR
RELEASE OF PROTECTED HEALTH INFORMATION

Part Two of Authorization Form

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 ___Personal Accounting Services_____ (healthcare provider) to use and disclose protected heath information described below to _____ (individual seeking the information).

2. Effective Period

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

   □ _____ to _____.

   OR

   b. X 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
      □ Other (please specify): _____

4. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

5. This authorization shall be in force and effect until 30 days after Personal Accounting Services is no longer providing services on my behalf (date or event), at which time this authorization expires.

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 the information used or disclosed pursuant to this authorization may be disclosed by the receipt and may no longer be protected by federal or state law.

Signature of patient or personal representative

Printed name of patient or personal representative and his or her relationship to the patient

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Date