HIPAA Authorization

Rejuvenate Healthcare, LLC.
Mailing Address:
638 Miami Manor
Maumee, Ohio 43537
Phone: 419-481-8150
FAX: 419-932-6935

Authorization for Disclosure of Medical Information

Patient's Name:_____Date of Birth:_____SSN: _____

Address:_____

City: _____State:_____ Zip: _____

Daytime Telephone:_____Evening Telephone: _____

E-mail address:_____

I hereby authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider that has provided payment, treatment or health care services to me or on my behalf to disclose all of my medical records in their possession, including the following, if applicable:

- My complete health record including, but not limited to, diagnosis, lab test results, treatment, and billing records for all conditions;
- Mental health records
- Communicable diseases including, ,but not limited to HIV and AIDS
- Alcohol and Drug Abuse Treatment records protected by 42 C.F.R. Part 2
- Records pertaining to sexually transmitted diseases
- Genetic Test Results

Mail To Rejuvenate Healthcare, LLC, Susan Rees, BSN 638 Miami Manor, Maumee OH 43537

Corporate Office 921 11th Street, Suite 1100, Sacramento, California 95814, to be used to help me improve the management of my kidney disease.

This authorization is valid from (date)_____to the date my participation in the Rejuvenate Healthcare, LLC kidney disease management program ends.

By signing below:

- I understand that Rejuvenate Healthcare, LLC will share my information with healthcare providers, hospitals, the Alliance for Paired Donation and other entities for the purpose of attempting to improve the management of my kidney disease.
- I understand that I am not obligated to sign this Authorization form, that I do so voluntarily, and that my health care, the payment for my health care, and my health care benefits will not be affected if I do not sign this form. However, I understand that I will not be able to participate in the Rejuvenate Healthcare kidney disease management program if I do not sign this form.
- I understand that my healthcare/insurance providers must follow federal and state privacy laws when using and sharing my information, but that other entities receiving my information pursuant to this authorization may not have to follow the same privacy laws and, therefore, may share my information with others without being subject to penalties under those laws. However, I understand that Rejuvenate Healthcare, LLC will not share my information with any entity outside of their kidney disease management program, their contractors and/or the participating healthcare providers, hospitals and transplant centers without my permission.
- I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. This authorization will automatically expire when I end my participation in kidney disease management program of Rejuvenate Healthcare LLC.
- I understand that I can get a copy of this authorization form that I have signed by sending Rejuvenate Healthcare, LLC a signed request using the address at the top of this form.
- I understand that Rejuvenate Healthcare, LLC will be working with me to improve the management of my kidney disease. I acknowledge that Rejuvenate Healthcare, LLC may identify services or opportunities to improve my healthcare condition that exceed or fall outside the coverage parameters of my current healthcare plan, and which, due to lack of coverage through my current healthcare plan, may prove cost prohibitive. I hereby waive any claims I may have against Rejuvenate, now or in the future, arising out of or related to any such services.

_____ _____
Signature of Patient or Personal Representative Date

_____
If Personal Representative, source of authority to act for Patient

_____ _____
Signature of Witness Date

For this Authorization Form to be valid, it must be filled out accurately and completely.

Return this form to the HIPAA Privacy Officer, Rejuvenate Healthcare, LLC,
Mailing Address due to COVID- Susan Rees, BSN 638 Miami Manor Maumee, Ohio 43537
Home Office 921 11th Street, Suite 1100, Sacramento, California 95814 or email it to
sue@rejuvenatehealthcare.com .