AUTHORIZED USE AND DISCLOSURE FORM

Note: This form is used to confirm a Member's permission that SAMBA may use or disclose their personal health information. Use and disclosure of their information is strictly limited to that purpose described in section B below.

Section A: Member Information

Member Name *(last, first, mi)**:***

Address:

Plan Code: **SSN/ID Number:**

Section B: Type of Information

This authorization provides for use and disclosure of only that protected health information described below and only for the purposes indicated:

Section C: Limitations and Disclosures:

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

SAMBA will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits on whether I provide authorization for the requested use or disclosure.

I understand that I have the right: to inspect or copy the protected health information to be used or disclosed as permitted under federal law (or state law to the extent that the state law provides greater access rights); and the right to refuse to sign this authorization.

The use or disclosure requested under this authorization will result in direct or indirect remuneration to SAMBA from a third party, if applicable.

Section D: Expiration and Revocation

This authorization shall be in force and effect until _____ at which time this authorization to use or disclose this protected health information expires.

I understand that I have the right to revoke this authorization, in writing, at any time by sending written notification to SAMBA Privacy Official, 11301 Old Georgetown Road, Rockville, MD 20852. I understand that my revocation of this authorization will not affect any action that you have taken, or any information that you have already released, based upon this authorization before you actually receive my request to revoke it.

Section E: Signature/Authorization

I have had an opportunity to read and consider the content of this Authorized Use and Disclosure Form. I understand that by signing this form, I am confirming my authorization that SAMBA may use and/or disclose my personal health information for the purposes described above.

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Signature: **Date:**

Representative's Name *(print last, first, mi)*:

Representative's Signature: **Date:**

Representative's Relation to Individual *(Patient)* or Explanation of Authority to Sign for the Patient:

Please return the signed Authorized Use and Disclosure Form to:
SAMBA Privacy Official, 11301 Old Georgetown Road, Rockville, MD 20852, FAX 301 984-5860
You are entitled to a copy of this signed Authorized Use and Disclosure Form.