Medical Authorization & Release of Information

Print Name: _____ **Destination:** _____

The Health Insurance Portability and Accountability Act, also known as HIPAA, was created in 1996 by the US Congress to protect the privacy of your health information. The act prohibits your health care providers from releasing your health care information unless you have provided your health care provider with a HIPAA release form. Unless you have provided a signed release form, your health care providers are prohibited from discussing any aspect of your medical information with anyone who is not directly involved in your care.

Personal Insurance Company:_____

Group #_____ID#_____

Chronic Heath Problems_____

Allergies & Medication Allergies _____

Prescription Medications & Doses_____

HIPPA Release of Medical Information to Authorized Persons

I authorize the release of my personal health information to those persons listed below including the diagnosis, treatment, records, examination rendered to me, claims payment, and healthcare services provided or to be provided to me and which identifies my name, address, social security number, and member ID number for the purpose of helping me resolve claims and health benefit coverage issues. I understand that any personal health information or other information released to the persons listed below may no longer be protected by applicable federal and state privacy laws.

Check all that apply:

☐ Spouse: _____

☐ Relative: _____Relation: _____

☐ Child(ren): _____

☐ Other: _____

This Release of Information will Remain in Effect Until (check one): ☐ Terminated by me in writing,

☐ The following date: _____, ☐ Information is not to be released to anyone.

Medical Treatment Authorization

I authorize the calling of a doctor and the providing of necessary medical services in the event I am injured or become ill. I authorize any leader participating on this trip or any AGWM missionary to make emergency medical care decisions on my behalf, if required by law or a health care provider. I understand that the Northwest Ministry Network, Assemblies of God World Missions, or any of their agents, employees, or volunteers, will not be responsible for medical expenses incurred on the basis of this authorization. I agree to notify the Northwest Ministry Network sponsoring this trip in the event of any health changes which would restrict my participation in any activities. I also understand that the NWMN representatives reserve the right to restrict me from any activity that they do not feel is within my physical capabilities.

Signature

I understand that this authorization is effective upon signing and is voluntary. I also understand that I may refuse to sign this authorization and my refusal to sign will not affect my eligibility for benefits or enrollment or payment for or coverage of services.

Signed: _____Date:_____