General Authorization for Release of Claim Payment Information

I. Information About the Use or Disclosure

I hereby authorize the use or disclosure of my individually identifiable health information as described below.

My Name: _____ ID#: _____

Persons/organizations authorized to **provide** the information: S&S HealthCare Strategies, Ltd.

Persons/organizations authorized to **receive** the information: _____

_____

Specific description of information to be used or disclosed:

_____

_____

Specific purpose of the disclosure:

Per my request.

This authorization will expire: _____

Indicate date or an event relating to you personally. If no date is listed, authorization will expire one year after the date of the signature below.

II. Important Information About Your Rights

I have read and understood the following statements about my rights:

- I may revoke this authorization at any time prior to its expiration date by notifying the providing organization in writing, but the revocation will not have any effect on any actions that the entity took before it received the revocation.
- I may see and copy the information described on this form if I ask for it.
- The information that is used or disclosed pursuant to this authorization may be further disclosed by the receiving entity.

III. My Signature or My Representative's Signature *(ONLY ONE OR THE OTHER – If patient signs, no personal representative need be listed.*

_____ _____

Signature of patient or patient's representative Date

Printed Name of personal representative: _____

Authority for status as personal representative: _____

(Attach documentation supporting status, unless the personal representative is the parent of the patient who is a minor child)

COMPLETE ALL FIELDS OR THE AUTHORIZATION WILL BE INVALID.

Return completed form to S&S HealthCare Strategies, Ltd., 1385 Kemper Meadow Drive, Cincinnati, OH 45240
ATTN: HIPAA Compliance Officer, or fax to 513-772-9174