AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (HIPAA Compliance)

This release must be signed and dated before your application can be considered for expense reimbursement.

I hereby authorize my health care provider to disclose my protected health information described below to ITVERP. You may disclose this information to: ITVERP, Office for Victims of Crime, 999 N. Capitol St. NE, Washington, DC, 20531; by fax: 202–514–6383 or e-mail: itverp@usdoj.gov.

I hereby authorize any physicians, clinics, psychologists, dentists, chiropractors, nursing homes, pharmacies, acupuncturists, or naturopaths to furnish ITVERP program representatives with any information requested, including medical records, diagnostic assessments, and mental health evaluations, needed to complete my claim for expense reimbursement. A photocopy of this authorization shall be considered as effective and valid as the original.

I hereby authorize any health insurance companies, HMOs, employer health plans, and government programs such as Medicare, Medicaid, and military and veterans' health care programs to furnish to ITVERP program representatives with any information requested, including medical records, diagnostic assessments, and mental health evaluations, needed to complete my claim for expense reimbursement. A photocopy of this authorization shall be considered as effective and valid as the original.

I hereby authorize funeral director, municipal authority, employer or union, insurance company, social service bureau, Social Security office, or any other person, firm, agency, or organization to furnish ITVERP program representatives with any information requested to complete my claim for expense reimbursement. A photocopy of this authorization shall be considered as effective and valid as the original.

This authorization expires when ITVERP completes verification of my claimed expenses.

Revocation: I understand that if I revoke this authorization, the ITVERP expense verification process cannot be completed. I understand that to revoke this authorization I must submit a written letter to ITVERP stating authorization is revoked, or I may contact the ITVERP program representative and verbally revoke authorization. I understand revocation is only effective after it is received and recorded by ITVERP. Any use or disclosure made prior to revocation will not be affected as part of this revocation.

Victim/Claimant Printed Name	Date
Victim/Claimant Signature	Date
Representative's Printed Name	Date
Representative's Signature *(or signature of individual who assisted in the preparation of this application)*	Date