VALHALLA HEALTHCARE

# Authorization To Use, Disclose, or Obtain Personal Health Information

**Patient Name:** _____ **DOB:** _____

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**I am signing this Authorization because:** I wish to authorize the healthcare providers in my Valhalla healthcare "Network" (as defined in the Valhalla Privacy Policy that I am signing in conjunction with this Authorization), and Valhalla Healthcare, Inc., to communicate with me and with each other regarding my healthcare through the Allevia mobile software application ("Allevia").

**I understand that, by signing this Authorization, I am authorizing the healthcare providers listed below (the "Providers"), and Valhalla itself, to use, disclose, and obtain my Personal Health Information (defined below).** The Authorization is intended to satisfy the legal requirements of the Health Insurance Portability and Accountability Act (42 U.S.C. § 1320d) (HIPAA) and state privacy laws.

*Authorization to Use, Disclose, and Obtain My Personal Health Information*
I hereby authorize the Providers, as well as Valhalla itself, to use, disclose, or obtain my Personal Health Information for the purposes described herein. I understand and intend that this Authorization will not be effective as to any Provider unless and until the Provider joins my Network.

*Authorization for Specific Types of Personal Health Information*
I understand that if my Personal Health Information contains the following types of information, I hereby consent and authorize the Providers and Valhalla to use or disclose it for the purposes described herein.

- HIV test results[1]
- Genetic screening test results
- Alcohol and drug abuse history
- Sexually transmitted disease (STD) information
- Domestic violence/sexual assault counseling
- Mental health diagnosis/treatment

*Persons and Entities to Whom the Provider Is Authorized to Disclose My Personal Health Information*
I hereby authorize each of the following Providers, as well as Valhalla, to disclose my Personal Health Information to, obtain my Personal Health Information from, and discuss my Personal Health Information with, Valhalla and each of the following Providers:

| Providers | Location/Contact |
|---|---|
| | |
| | |
| | |

My Providers are governed by HIPAA as "covered entities," and Valhalla is governed by HIPAA as the Provider's "business associate." HIPAA requires the Provider and Valhalla to safeguard the security and privacy of my Personal Health Information. But other third parties may not be governed by HIPAA. If I give access to my account or my Network to any such third parties, my Personal Health Information may be subject to re-disclosure by such third parties, and it may not be possible to protect the privacy of such information. I hereby release the Providers, Valhalla, and the employees of the Providers and Valhalla from any liability arising from the re-disclosure of this information by such third parties.

Unless I have specifically requested in writing that the disclosure of information be made in a certain format, I understand and agree that the Providers reserve the right to disclose information as permitted by this authorization in any manner that it deems to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format, or electronically.

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[1] I understand that authorizing the disclosure of this information could have adverse consequences if the information is misused. This may include discriminatory treatment, whether lawful or unlawful. I understand that the Providers will protect the confidentiality of information about my HIV status, sexually transmitted disease status, and all my healthcare records, as the law requires.

*Description and Purposes of Using/Disclosing/Obtaining Personal Health Information*

This Authorization covers my "Personal Health Information." My Personal Health Information includes all information that is disclosed by, between, or among myself, the Providers, and Valhalla through use of Allevia. It includes but is not limited to the information, communications, and documents that comprise my "Primary User Information" (as defined in the Valhalla Terms of Use). Personal Health Information also includes (but is not limited to) all information that relates to my diagnosis, treatment, payment, criminal record information, healthcare services, continuing care plans, demographic information, treatment progress, and assessment. It may also include information in my medical record, as well as any and all other "Protected Health Information" as defined by HIPAA.

I understand that the purpose of using, disclosing, or obtaining this information is to improve assessment and treatment planning, to share information relevant to treatment, to coordinate treatment services, to improve health care operations, assist in billing for payment of services, and generally to facilitate the coordination of my healthcare between and among the members of the Network.

*My Rights*

**By signing below, I acknowledge that I have read this authorization and understand that:**

- I may refuse to authorize the disclosure of the above healthcare information. My Providers will not condition my ability to receive healthcare services or treatment on providing or refusing to agree to this Authorization. But if I refuse to agree to this Authorization, I will not be permitted to use Allevia.
- I may revoke this Authorization at any time by notifying Valhalla's Privacy Officer by email at **support@valhalla.healthcare** or by telephone at (781) 366-0310. I may also revoke this Authorization by terminating my Allevia account. Revoking this Authorization will not apply to information that was already used/disclosed/obtained in reliance on my having signed this form.
- The health information that is disclosed pursuant to this Authorization may be subject to re-disclosure by a recipient, and it may not be possible to protect the privacy of this information once re-disclosed.
- I have the right to make a written request to review my records before signing. I have the right to receive copies of my records for a reasonable fee.
- I have a right to a copy of this signed authorization.

I understand that this authorization will remain in effect until I revoke it as described above, or until I terminate my account with Valhalla.

I have read and understand the terms of this authorization. I have had an opportunity to ask questions about the use and disclosure of my Personal Health Information. By my signature below, I hereby knowingly and voluntarily authorize the Providers and Valhalla Healthcare, Inc., to use, disclose, and/or obtain my Personal Health Information in the manner described above.

_____ _____

[X] Patient Name Date

OR

If the Patient is incapacitated (physically or mentally):

_____ _____

[ ] Guardian/Personal Representative Date

_____

Authority or Relationship