



A subsidiary of
LIBERATOR MEDICAL HOLDINGS, INC.

2979 SE Gran Park Way ~ Stuart, FL 34997
Phone: 1-888-796-4733 Fax: 800-755-0843

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

By signing below, I authorize _____
to disclose Protected Health Information about me as described below:

The information to be disclosed consists of:

Certificate of Medical Necessity, Letter of Medical Necessity, Progress Notes, and any other information/documentation needed to process an insurance claim for the product(s) supplied to me.

The information described above may be disclosed to: ***Liberator Medical Supply, Inc. and its authorized agents.***

The purpose of this disclosure is: **to process insurance claims for the product(s) or service(s) they have provided to me that may be required by my insurer(s).**

This authorization shall terminate effective **November 14, 2009**, if no specific date has been indicated the authorization shall terminate automatically once the disclosure(s) have been made, or one year from the date of signature, whichever occurs first. This authorization may be revoked at any time by sending a written request to the address provided above, except to the extent that the disclosing party has taken action in reliance upon this authorization. Some authorized recipient(s) may not be subject to federal health data privacy regulations. Accordingly, the information disclosed under this authorization may be used or re-disclosed without those legal protections. This authorization is not a condition for receiving any treatment, payment or benefit from the disclosing individual or entity. However, refusal to sign this authorization may affect Liberator Medical Supply, Inc.'s ability to obtain the information necessary to bill my insurance carrier(s). I understand that I am entitled to a copy of this authorization.

Patient Name: _____

Signature of Patient or Personal Representative: _____

Date: _____

If signed by representative:

Name of representative: _____
(PRINT)

Description of Authority: _____ Basis for Verification: _____