CAMP EXCHANGE USA

PRIVACY, HIPAA, AND CONFIDENTIALITY RELEASE

By completing this form, you give consent to CIEE, your parents or guardian, and your physicians and/or other medical providers to discuss your medical and/or insurance issues with CIEE. You also consent to CIEE utilizing any such material as necessary in treating any medical condition that may arise. You also give consent that CIEE may notify your emergency contact listed in this application of any situation that we deem to be an emergency. In addition, you give consent that CIEE may notify the official CIEE-designated agency from whom you purchased this program of any situation that we deem to be an emergency.

This authorization is valid for two years from the date signed.

Under no circumstances can CIEE release medical information from your physician or provider of service to you or anyone. Your medical information has been disclosed to us by your physician or provider of service, and we are prohibited by federal law from further disclosure. Please contact your physician or provider of service for your medical information.

I give CIEE permission to release any or all of the following information as appropriate in the event of a medical condition. *(Please initial and check each box.)*

Initial:	☐ All financial and claim information related to medical bills or Claimant's Statement and Authorization.
Initial:	☐ Name, date of service, total charge, total paid, and date of payment.
Initial:	☐ Insurance ID number and/or social security number.

Print Patient Name: _____ **Date** (DD/MM/YYYY): _____

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Signature of the Patient: _____