Authorization for Use and Disclosure of Protected Health Information Pursuant to HIPAA 45 C.F.R. §164.508

To:____ **(Insurer or Other Disclosing Party)**

Re:____ **(Plaintiff/Beneficiary/Claimant)**

I hereby authorize the above noted disclosing party and/or their agents to release, upon request, certain protected health information to MASSIVE (f/k/a/ Med Lien Solutions) for the purpose of disclosure and resolution of healthcare and medical liens. The health plan is hereby authorized to disclose: All enrollment information, medical records and payment information (including itemizations of said payments and supporting information such as ICD-9/10 codes) related to the injury/illness. This authorization covers the release of all past, present, and future records.

I have had full opportunity to read and consider the contents of this document and I understand that my health plan may not condition my enrollment, my eligibility, my treatment, or payment for such services on whether this authorization is signed.

I further authorize MASSIVE (f/k/a/ Med Lien Solutions) to **make any changes, waivers, disputes, and take any other necessary actions to fully resolve the lien on my case**. This notice serves as proof of MASSIVE (f/k/a/ Med Lien Solutions) representation of the undersigned.

REVOCATION: I understand that I may refuse to sign this authorization & that I may revoke it at any time, but I must do so in writing to the above-noted disclosing party. The revocation will not be effective to the extent that information has already been disclosed pursuant to this authorization. I understand that I have the right to receive a copy of this authorization after it is signed.

RE-DISCLOSURE: I understand that the persons to whom information is disclosed under this authorization may possibly re-disclose the information to others without my knowledge of consent and therefore the privacy of my personal and health information may no longer be protected by law.

STDs and **BEHAVIORAL HEALTH**: I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse

Person(s)/Entity Authorized to Receive Information:
MASSIVE (f/k/a/ Med Lien Solutions)
PO Box 687
Southfield, MI 48037
(833) 466-2774

Expiration: This Healthcare Lien and Subrogation Authorization expires upon resolution of the matter for which it was intended, or, if revoked by me at an earlier time.

Injured Person's Information:

Injured Person's Name (as shown on insurance card): ______________________________

I authorize the disclosure described herein. I have read and understand this authorization. I am the beneficiary listed on this authorization or am authorized to act on behalf of the beneficiary as the beneficiary's personal representative.

____
Signature

Date Signed: ____________________

If signed by a person other than the beneficiary/member please see the attached proof of legal relationship/letters of authority