Duncan v. Aliera Settlement – **CERTIFICATION AND HIPAA RELEASE**

I hereby certify that (check one):

□ I paid the total monthly payments for Unity/Aliera health plans and was not reimbursed for this cost by any other entity. OR

□ I or my dependents incurred out-of-pocket expenses, or debt, for uncovered medical expenses while enrolled with Unity/Aliera as set forth on the claim form on the back of this page and any additional pages I have attached. I further certify that the information provided in this Claim Form is true and correct under penalty of perjury under the laws of the United States.

I also authorize Sirianni Youtz Spoonemore Hamburger, PLLC or its designee ("Attorneys") to investigate my claims and, if deemed necessary and appropriate, to represent me to negotiate with the medical providers identified in my claim to reduce the amount of the debt owed and/or to resolve collections efforts against me with regard to the unpaid medical expenses.

I further authorize each medical provider identified in my claim to discuss my health condition, diagnosis, treatment, health coverage, insurance and billing information and release all records related to such information to Attorneys. I understand that I have the right to revoke this authorization any time by delivering my written revocation to each provider. I understand I may revoke this authorization except to the extent that action has already been taken based on it. Unless otherwise revoked, this authorization expires 180 days from the date of my signature.

I understand that signing this authorization is voluntary. I understand I may inspect or copy the information to be used or disclosed, as provided in 45 CFR §164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure after which the information may not be protected by federal confidentiality rules.

I understand my express consent is required to release information relating to testing, diagnosis, and/or treatment for HIV/AIDS, sexually transmitted diseases, behavioral health conditions, including psychotherapy notes, or drug and/or alcohol use or abuse. If the following space is initialed by me, you are specifically authorized to release all such information relating to the claimant:_____.

I agree that photocopies, faxes, or digital copies of this authorization will be as valid as the original. If additional HIPAA authorization forms are required to enable Attorneys to negotiate on my behalf, I agree to complete such forms.

Signature: _____ Date: _____

Type or Print Your Name (required): _____

Current Address: _____
(Street or P.O. Box)

_____
City, State and Zip Code

Daytime/Evening Telephone Numbers: _____ (day) _____ (eve.)

Email Address: _____

If you received this notice in the mail, please write your identification number (from the address label on the envelope) here: _____