Health Insurance Portability and Accountability Act (HIPAA) Policy Notice

A signed and fully completed copy of this **HIPAA Policy Notice** must be on file before any of the following searches can be rendered.

Hospital Checks (or any report that includes hospital checks), **Pharmacy Checks** and **Medical Provider Check** services provided by ***Factel, Inc***. are intended for insurance claims, litigation, or underwriting evaluation purposes, and then only as the information provided pertains to workers compensation, PIP, uninsured motorist, 3rd party, life or casualty insurance applications. They are not intended for use by any other person or entity for any other purpose.

Factel, Inc. ***will not*** provide **Hospital Checks, Pharmacy Checks** or **Medical Provider Checks** for any reason other than as described above.

By initialing and signing this acknowledgement I certify that any **Hospital, Pharmacy** or **Medical Provider Check** service I order will be in accordance with the intended purposes and/or procedures under which ***Factel, Inc.*** agrees to furnish such information.

I understand that ***Factel, Inc.*** is not a covered entity as described in **HIPAA** and does not provide **HIPAA** regulated information to covered entities as defined in the **Act,** or to representatives or business associates of covered entities.

By initialing on the line at the end of this paragraph and signing this **Notice** I certify that any requests I make for **Hospital Checks, Pharmacy Checks,** or **Medical Provider Checks** will not be made on behalf of a covered entity as described in **HIPAA** or for any person or organization representing a covered entity. _____

Signed By: _____ Date:_____

Printed Name and Title: _____

Company or Firm Name: _____

Address: _____

Telephone No. _____ Fax No. _____

Email Address: _____