HIPAA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information
(As required by the Health Insurance Portability and Accountability Act – 45 CFR Parts 160 and 164)

1. Authorization

I,_____ (please print patient name) hereby authorize _____ (health care provider) to use and/or disclose my protected health information (PHI) described below to _____ (healthcare provider).

2. Effective Period

Authorization for release of PHI covering the period of healthcare (check one)

☐ from (date) _____ to (date) _____

☐ for one year from today's date.

3. Extent of Authorization

☐ I hereby authorize my complete health record (including records relation to mental health care, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).

☐ I hereby authorize the release of my complete health record with the exception of the following information:

□ Mental health records
□ Communicable diseases (including HIV and AIDS)
□ Alcohol/drug abuse treatment
□ Other (please specify): _____

4. In addition to the authorization for release of my PHI described in section 3 of this Authorization Form, I authorize disclosure of information regarding my billing, condition, treatment and prognosis to the following individual(s):

Name_____Relationship_____

Name_____Relationship_____

Name_____Relationship_____

5. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

6. This authorization shall be in force and effect until _____(date or even), at which time this authorization expires.

7. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

8. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

9. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____ Date: _____

Signature of Patient