HIPAA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information

(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)**

1. Authorization**

   I authorize _____ (healthcare provider) to use and disclose the protected health information described below to _____ (individual seeking the information).

2. Effective Period**

   This authorization for release of information covers the period of healthcare from:

   a. ☐ _____ to _____.

   OR

   b. ☐ all past, present, and future periods.

3. Extent of Authorization**

   a. □ I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).

   OR

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

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

6. 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.

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

8. 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.

_____
Signature of patient

_____
Printed name of patient

_____
Date

Type of Identification produced:

_____