**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/agency to be provided 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 receive  this informationfor 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) (or one year from the date of signature) , 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.

Printed name of patient or personal representative and his or her relationship to patient

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of patient or personal representative Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_