

## HIPAA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information

(Required by the Health Insurance Portability and Accountability Act - 45 CFR Parts 160 and 164)

1. I hereby authorize all medical service sources and health care providers to use and/or disclose the protected health information (PHI) described below to my agent identified in my durable power of attorney for health care named \_\_\_\_\_.

2. Authorization for release of PHI covering the period of health care (check one)

a.  from (date) \_\_\_\_\_ - to (date) \_\_\_\_\_ OR

b.  all past, present and future periods.

3. I hereby authorize the release of PHI as follows (check one):

a.  My complete health record (Including records relating to mental health care, communicable diseases, HIV or AIDS, and treatment of alcohol/drug abuse). OR

b.  My complete health record with the exception of the following information (check as appropriate):

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 paragraphs 3 a and 3 b of this Authorization, I authorize disclosure of information regarding my billing, condition, treatment and prognosis to the following individual(s):

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_

5. This medical information may be used by the persons 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 nine (9) months after my death or \_\_\_\_\_, (date or event) 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.

**I DO NOT AUTHORIZE THE RELEASE OF MY RECORDS**

Signature of Patient \_\_\_\_\_ Date: \_\_\_\_\_

**Keep original, and give copies to your health care provider, agent and family members**