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 provide) to use and disclose the protected health information described below to _____ (DOB _____).
(individual receiving authorization)

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2. **Effective Period**

This authorization for release of information covers the period of healthcare from:
☐ _____ to _____ OR ☐ All past, present and future periods.

*

3. **Extent of Authorization**

☐ I authorization for release of my complete health records (including records relating to mental healthcare, communicable disease, HIV or AIDS, and treatment of alcohol or drug abuse).

OR

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

- ○ Mental health records
- ○ Communicable disease (including HIV and AIDS)
- ○ Alcohol/ drug abuse treatment
- ○ Other (Specifically): _____

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4. 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.

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

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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.

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

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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 or personal representative Date

_____
Print patient's complete name **Date of birth (mm/dd/yyyy)**