HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

Patient Name:_____ **DOB:**_____/_____/_____
Address:_____
Phone Number:(_____) _____-_____ **SSN:**_____-_____-_____

I authorize _____ ("Authorized Party") to use or disclose the following: (check one)
□ All of my medical-related information
□ My medical information ONLY related to:_____
□ My medical-related information from _____, 20____ to _____, 20____
□ Other:_____
Hereinafter known as the "Medical Records."

The Authorized Party has my authorization to disclose Medical Records

TO:

Name:_____
Address:_____
Phone:(_____) _____-_____ F:(_____) _____-_____

FROM:

Name:_____
Address:_____
Phone:(_____) _____-_____ F:(_____) _____-_____

Purpose for Disclosure:_____
This authorization will expire on the following: **Date:**_____ or **Event:**_____

Sensitive Information: This medical record may contain information about physical or sexual abuse, alcoholism, drug abuse, sexually transmitted diseases, abortion, or mental health treatment. Separate consent must be given before this information can be released.
□ **I consent** to have the above information released □ **I DO NOT consent** to have the above information released

HIV/AIDS: This medical record may contain information concerning HIV testing and/or AIDS diagnosis or treatment. Separate consent must be given to have this information released.
□ **I consent** to have the above information released □ **I DO NOT consent** to have the above information released

ACKNOWLEDGMENT OF RIGHTS

I understand that I have the right to revoke this authorization, in writing and at any time, except where uses or disclosures have already been made based upon my original permission. I might not be able to revoke this authorization if its purpose was to obtain insurance.

I understand that uses and disclosures already made based upon my original permission cannot be taken back.

I understand that it is possible that Medical Records and information used or disclosed with my permission may be re-disclosed by a recipient and no longer protected by the HIPAA Privacy Standards.

I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create Medical Records for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization.

I will receive a copy of this authorization after I have signed it. A copy of this authorization is as valid as the original.

Signature:_____ **Date:**_____
Print Name:_____

(IF THE PATIENT IS UNABLE TO SIGN, USE THE SIGNATURE AREA BELOW)

The patient is unable to sign due to: (check one)

□ **Being a minor:** Patient is ____ years old and considered a minor under state law.
□ **Being Incapacitated.** Patient is incapacitated due to:_____
□ **Other:** _____

Signature of Representative:_____ **Date:**_____

Print Name: _____