HIPPA PRIVACY AUTHORIZAION

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**** Authorization for Use or Disclosure of Protected Health Information**

(Required by the Health Insurance Portability and Accountability Act, 45C.F.R. Parts 160 & 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:

☐ _____ to _____

OR

☐ All past, present and future periods.

3. Extent of Authorization

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

OR

☐ I authorize the release of my complete health record except for the following information:

- o Mental health records
- o Communicable diseases (including HIV and AIDS)
- o Alcohol/drug abuse treatment
- o Other (please specify): _____

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.

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 insure has a legal right to contest a claim.

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

8. I understand that information used or disclosed by the pursuant and may no longer be protected by federal or state law.

Signature of patient or personal representative: _____

Printed name and relationship to patient: _____

Date: _____

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