Michele Delzer, CNP

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HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

This form is used when authorization is required under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

Date: _____
Patient Name: _____
Date of Birth: _____

AUTHORIZATION

I authorize _____
("Authorized Party," hereinafter known as the "Medical Records") to use or disclose the following (check one):

☐ All of my medical-related information.
☐ ONLY my medical information related to: _____
☐ My medical-related information from: _____ to _____
☐ Other: _____

DISCLOSURE

The Authorized Party has my permission to disclose Medical Records to (check one):

☐ Any party approved by the Authorized Party.
☐ ONLY the following party:
Name: Michele Delzer
Organization: Rapid City Health Professionals
Address: 3939 Canyon Lake Drive, Suite B
Phone: 605-716-3555
Fax: 605-699-7518
E-Mail: mmdelzer@rchealthpros.com

PURPOSE

The reason for this authorization is (check one):

☐ General purpose/continuity of care (at my request).
☐ To receive payment.
☐ Other: _____

ACKNOWLEDGMENT OF RIGHTS

- I understand that I may revoke this authorization **in writing at any time**, except to the extent that disclosures have already been made based on this authorization.
- I understand that disclosures already made cannot be taken back.
- I understand that information disclosed with my permission may be re-disclosed by the recipient and may no longer be protected by HIPAA standards.
- I understand that my treatment cannot be conditioned on signing this authorization (unless treatment is sought only to create records for a third party or for a research study).
- I will receive a copy of this authorization after signing it. Copies are as valid as the original.

Printed Name: _____
Signature of Patient: _____ **Date:** _____

ADDITIONAL CONSENT FOR CERTAIN CONDITIONS

This medical record may contain sensitive information. Separate consent is required to release this information.

Sensitive Information

May include: physical/sexual abuse, alcoholism, drug abuse, sexually transmitted diseases, abortion, or mental health treatment.

☐ I consent to have the above information released.
☐ I do not consent to have the above information released.

Printed Name: _____

Signature of Patient: _____ **Date:** _____

HIV/AIDS Information

This medical record may contain information regarding HIV testing and/or AIDS diagnosis or treatment. Separate consent is required to release this information.

☐ I consent to have this information released.

☐ I do not consent to have this information released.

Printed Name: _____

Signature of Patient: _____ **Date:** _____