# 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

Mass Functional Medicine P.C.

I, _____, _____ , authorize
PRINTED FULL NAME RELATIONSHIP TO PATIENT

Mass Functional Medicine, P.C., (healthcare provider) to use and disclose the protected health information, described below, for patient,

_____ (guardian/individual seeking the information).
FULL NAME OF PATIENT

## 2. Effective Period

This authorization for release of information covers the period of healthcare from

a. ☐ _____ to _____ ** OR **
MM/DD/YYYY MM/DD/YYYY

b. ☐ all past, present, and future periods.

## 3. Extent of Authorization

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

** OR **

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

□ Mental health records

□ Communicable diseases (including HIV and AIDS)

□ Alcohol/drug abuse treatment

□ 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 _____
(MM/DD/YYYY 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/the patient's 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.

7. I understand that my/the patient's treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

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.

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|---|---|
| Signature of patient or personal representative. | Printed full name of patient or personal representative |
| Relationship to patient | MM/DD/YYYY |