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Authorization to Obtain or Release Protected Health Information

Health Insurance Portability and Accountability (HIPAA) Act 45 C.F.R. Parts 160 & 164

I authorize ____ (healthcare provider) to use and disclose the protected healthcare information described below to ____ (individual seeking the information).

Effective Period: This authorization for release of information covers the period of healthcare from: (Check One)

___ A (Date) ____________________________ to ____________________________

Or:

___ B All past, present and future periods.

Extent of Authorization:

___ A I authorize the release of my complete health record (including records relating to mental healthcare, communicable disorders 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) ____

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- 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 direct.
- This authorization shall be in force until ________________ (date or event), at which time the authorization expires.
- 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 the legal right to contest a claim.
- I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.
- 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 (or parent/guardian if patient is under age 18)

____

Printed name of patient or personal representative (or parent/guardian if patient is under age 18)

____

Witness

____

Date