**Form 4 YCMC HIPPA Privacy Authorization Form**

HIPPA PRIVACY AUTHORIZATION

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION (REQUIRED BY THE HEALTH INSURANCE PORTIBILITY AND ACCOUNTABILITY/ACT-45 CFR PARTS 160 AND 164

1. I HEREBY AUTHORIZE REBECCA L MCCLAIN, FNP-C TO USE AND/OR DISCLOSE THE

PROTECTED HEALTH INFORMATION DESCRIBED BELOW TO THE FOLLOWING PERSON(S).

**Name of Individual, Relationship to Patient**

**Name of Individual, Relationship to Patient**

**Name of Individual, Relationship to Patient**

1. AUTHORIZATION FOR RELEASE OF INFORMATION. COVERING THE PERIOD OF HEALTHCARE FROM:

**Beginning date of authorization**

**Ending date of authorization**

OR

 All past, present and future periods

 I hereby authorize the release of my complete health record (including records relating to mental health care, communicable diseases, HIV or AIDS, and treatment of alcohol/drug abuse

OR

**I hereby authorize the release of my complete health record with the exception of the following information:**

 Mental Health Records  Communicable Diseases  Alcohol/Drug abuse treatment

 Other

**If other, please specify**

THIS MEDICAL INFORMATION MAY BE USED BY THE PERSON (S) I AUTHOIZE TO RECEIVE THIS

INFORMATION FOR MEDICAL TREATMENT OR CONSULTATION , BILLING OR CLAIMS PAYMENT, OR OTHER PURPOSES AS I MAY DIRECT

**Patient's Name**

*Please print*

**Patient's Signature**

**Date:**