



HIPAA AUTHORIZATION - PATIENT'S AUTHORIZATION RELEASE OF MEDICAL RECORDS

THIS FORM IS TO CONFIRM YOUR AUTHORIZATION TO USE OR DISCLOSE YOUR PROTECTED HEALTH INFORMATION FOR A SPECIAL PURPOSE.

- 1. INDIVIDUAL PATIENT (OR PERSONAL REPRESENTATIVE) CONFIRMING THE AUTHORIZATION** - I voluntarily give my authorization to use or disclose my protected health information as described below.

Patient's Name & Address : _____

Patient's Date of Birth & Date of Injury: _____

- 2. THE USE AND/OR DISCLOSURE BEING AUTHORIZED** - Describe your protected health information you are authorizing us to disclose: (example: appointments, types of medication, copies of medical records, disability information, type of treatments received, entire chart) _____

Name the people and/or organizations you are authorizing to receive and use your protected health information. _____

3. ENDING THIS AUTHORIZATION

☐ This authorization will end on the following date: _____

☐ This authorization will end when the following event happens. The event must relate to the individual or the purpose of the authorized use and/or disclosure. (example: your attorney has settled your case) _____

- 4. CHANGING YOUR MIND ABOUT THIS AUTHORIZATION** - I understand that I may revoke this authorization at any time by giving written notice to the front-desk at your office. However, I understand that I may not revoke this authorization for any actions taken BEFORE receipt of my written notice to revoke this authorization. I also understand that if I am giving this authorization as a condition of obtaining insurance coverage and I revoke this authorization, the insurance company has a right to contest my claims under the insurance policy, which may result in my responsibility of the balance of my account.

- 5. SIGNING THIS AUTHORIZATION IS NOT A CONDITION OF TREATMENT** - I understand that under most circumstances, a healthcare provider may not condition treatment, payment, enrollment, or eligibility for benefits or my signing this authorization. Also, I may be required to sign an authorization if my treatment is provided solely for the purpose of creating protected health information for disclosure to a third party. And under some circumstances, a health plan may condition my enrollment in a health plan or my eligibility for benefits on my providing an authorization permitting the health plan to make enrollment and eligibility determinations.

I have had the chance to read and think about the content of this authorization form and I agree with all statements made in this authorization. I understand that by signing this form, I am confirming my authorization for use and/or disclosure of the protected health information described in this form with the people and/or organizations named in this form.

Signature: _____

Date: _____

Personal Representative Signature: _____ Date: _____

Personal Representative Name & Relationship to Patient: _____

PRIVACY PRACTICES ACKNOWLEDGMENT OF RECEIPT

I HAVE RECEIVED THE NOTICE OF PRIVACY PRACTICES AND I HAVE BEEN PROVIDED AN OPPORTUNITY TO REVIEW IT.

PATIENT SIGNATURE: _____ DATE: _____

PATIENT LEGAL NAME: _____ DATE OF BIRTH: _____

Signature Guardian/Personal Representative or Parent's Signature: _____ DATE: _____

Guardian/Personal Representative Full Name & Relation to patient: _____