**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\*\***

I authorize \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to use and disclose the protected health information described below to *RegenLIFE medical team collaborators.*

**\*\*2. Effective Period\*\***

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

a. □ \_\_\_\_\_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_\_\_\_. OR b. □all past, present, and future periods.

**\*\*3. Extent of Authorization\*\***

a. □ I authorize the release of my 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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (date), 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 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 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 Date

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Printed name of patient or personal representative and his/her relationship to patient Date

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Patient Address City State Zip

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Date of Birth: