HIPAA AUTHORIZATION

INSTRUCTIONS

A **HIPAA Authorization** gives permission to the individuals listed in the document to obtain your personal medical information and to communicate with your medical providers and insurance companies. This document is useful to permit parents or legal guardians to communicate with physicians, hospitals or a school infirmary if a child is ill while away at college. If you are a college student or young adult, you may want to list your parents or legal guardians in the HIPAA Authorization.

To complete the HIPAA Authorization:

1. Insert your name in the blank line in the first line of Paragraph 1 (Appointment of Authorized Recipients).

2. List the names of the people to whom you are giving permission to obtain your personal medical information and communicate with your medical providers in the blank lines in Paragraph 1 (Appointment of Authorized Recipients).

3. Take the form to a Notary Public and sign and date the form in the presence of the Notary. You may complete the form before you go to the Notary, but do not sign and date the form until you are in the presence of the Notary.

4. The Notary should complete the Notary clause below your signature, and sign and seal the document.

5. After the document is signed, retain the original document and give a copy to your primary care physician and the people named in the document.

Authorization for Release of Protected Health Information
(Valid Authorization Under 45 CFR Chapter 164)

Statement of Intent: The Health Insurance Portability and Accountability Act ("HIPAA") limits use, disclosure or release of my health information (or, sometimes herein, "protected medical information"). I am signing this Authorization because it is crucial that my health care providers readily use, release or disclose my protected medical information to, or as directed by, that person or those persons designated in this Authorization, to allow them to discuss with, and obtain advice from, others or to facilitate decisions regarding my health care, without regard to whether any health care provider has certified in writing that I am incompetent:

1. **Appointment of Authorized Recipients**. I, _____, an individual, hereby appoint the following persons, or any one of them, as Authorized Recipients for health care disclosure under the Standards for Privacy of Individually Identifiable Health Care Information (45 CFR Parts 160 and 164) under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"):

_____

_____

_____

2. **Grant of Authority.** I authorize a health care provider (a "covered entity" as defined by HIPAA) to use, release and disclose my individually identifiable health information in accordance with and as authorized by 45 CFR 164.502, 164.524 and 164.528. I specifically authorize any covered person or entity, including but not limited to any physician, healthcare professional, dentist, health plan, hospital, clinic, laboratory, pharmacy or other covered health care provider, any insurance company or health care clearing house that has provided treatment or services to me, that has paid for or that is seeking payment from me for such services, to give, disclose and release to the named individual(s) or any one or more of them, or as directed by any one or more of them, without restriction, all of my individually identifiable health information and medical records regarding any past, present or future medical or mental health condition.

3. **Termination.** This Authorization is not affected by, and shall not terminate by reason of, my subsequent disability or incapacity. This Authorization shall terminate 10 years following my death or upon my written revocation expressly referring to this Authorization and the date it is actually received by the covered entity. Proof of receipt of my written revocation may be by certified mail, registered mail, facsimile, or any other receipt evidencing actual receipt by the covered entity. Such revocation shall be effective upon the actual receipt of the notice by the covered entity except to the extent that the covered entity has acted in reliance on it.

4. **Re-disclosure.** By signing this Authorization, I acknowledge that the information used, disclosed or released pursuant to this Authorization may be subject to re-disclosure by an Authorized Recipient whose names are written in paragraph 1 of this Authorization and the information once disclosed will no longer be protected by the rules created in HIPAA. No covered entity shall require an Authorized Recipient to indemnify the covered entity or agree to perform any act in order for the covered entity to comply with this Authorization.

5. **Instructions to the Authorized Recipients.** An Authorized Recipient shall have the right to bring a legal action in any applicable forum against any covered entity that refuses to recognize and accept this Authorization for the purposes that I have expressed. Additionally, an Authorized Recipient is authorized to sign any documents that the Authorized Recipient deems appropriate to obtain use, disclosure or release of the protected medical information.

6. **Effect of Duplicate Originals or Copies.** If this Authorization has been executed in multiple counterparts, each counterpart original will have equal force and effect. An Authorized Recipient may make photocopies of this Authorization and each photocopy will have the same force and effect as the original.

7. **My Waiver and Release.** With regard to information disclosed pursuant to this Authorization, I waive any right of privacy that I may have under the authority of the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 (HIPAA), any amendment or successor to that Act, or any similar state or federal act, rule or regulation. In addition, I hereby release any covered entity that acts in reliance on this Authorization from any liability that may accrue from the use or disclosure of my protected medical information in reliance upon this Authorization and for any actions taken by an Authorized Recipient.

8. **Severability.** I intend that this authorization conform to United States and Massachusetts law. In the event that any provision of this document is invalid, the remaining provisions shall nonetheless remain in full force and effect.

I understand that I have the right to receive a copy of this authorization. I also understand that I have the right to revoke this authorization and that any revocation of this authorization must be in writing.

Dated: _____ _____

Commonwealth of Massachusetts

County of _____, ss.

On this _____ day of _____, 20____, before me, the undersigned notary public, personally appeared _____ ☐ personally known to me / ☐ proved to me through satisfactory evidence of identification, which was ☐ current driver's license ☐ other valid photo ID ☐ ID by another person with valid ID or known to me ☐ other:_____

to be the person whose name is signed on the preceding or attached document, and acknowledged to me that this document was ssigned voluntarily for its stated purpose.

_____
Notary Public
My commission expires: _____

(Official Seal of Notary Public)