**HIPAA PRIVACY AUTHORIZATION FORM**

Authorization for Use or Disclosure of Protected Health Information

(Required by the Health Insurance Portability and Accountability Act – 45 CFR Parts 160 and 164)

1. I hereby authorize to use and/or disclose the

**[NAME OF HEALTH CARE PROVIDER]**

1. protected health information described below to \_\_\_\_\_.

**[NAME OF INDIVIDUAL]**

1. Authorization for Release of Information. Covering the period of health care from

□ to

**□** 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).

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

* + 1. Mental health records
		2. Communicable diseases (including HIV and AIDS)
		3. Alcohol/drug abuse treatment
		4. Other (please specify):
1. 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.
2. This authorization shall be in force and effect until , at which time this authorization expires. **[DATE OR EVENT]**
3. 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.
4. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.
5. 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 |  | Date |