HIPAA PRIVACY AUTHORIZATION FORM

Authorization for Disclosure of Protected Health Information

I, _____, authorize _____

Individual Giving Authorization **Person Providing Information**

to disclose the following protected health information:

A. ____My complete medical record for services provided on or after the following date _____.
Unless this authorization is expressly limited by filling in Part B below, this authorization grants the Health Care Provider the right to release <u>all</u> personal medical information for the purposes described, including medical information about any diagnosis or treatment for any mental health, drug, alcohol or substance abuse condition, sexually transmitted diseases (such as HIV), cancer and the manifestation of and effects of a condition that happens to be genetic. It does not authorize the disclosure of any other genetic information or psychotherapy notes.

B.____Release only the following medical information from my medical record: (Specifically describe the information to released, including, but not limited to, meaningful descriptors such as date of service, type of service performed, level of detail to be released, origin of information etc.)

_____

_____

_____

This information may be released to _____.

Recipient

This information shall be provided for the purpose of_____.

Purpose of Disclosure

This authorization shall be in force and effective **[until _____/for_____ days/months/years]**.

I understand that:

- I have the right to revoke this authorization, in writing, at any time by sending such written notification to the person authorized to make the disclosure, identified above.
- My revocation will not be effective to the extent that the authorized person has relied on the authorization before receiving the revocation, but will be effective from that date forward.
- Failure to furnish this authorization will not affect my medical treatment/eligibility or enrollment for health coverage or the payment of health benefits.
- Once disclosed, the protected health information may no longer be protected by federal or state law and could be disclosed again by the recipient.

_____ _____

Signature of Individual or Personal Representative **Date**

If a personal representative is signing the form on behalf of the individual whose medical information is to be disclosed, please print the personal representative's name and describe his or her authority to act on behalf of the individual.

_____ _____

Name of Personal Representative **Authority of Personal Representative**

A fax or photocopy of this form shall be as effective as the original. A copy of this form shall be provided to the authorizing individual.