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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 all medical service sources and health care providers to use and/or disclose the protected health information (PHI) described below to my agent identified in my durable power of attorney for health care named _____.

2. Authorization for release of PHI covering the period of health care (circle one)
a. from (date) _____ to (date) _____ OR
b. all past, present, and future periods

3. I hereby authorize the release of PHI as follows (circle one):
a. my complete health record (including records relating to mental health care, communicable diseases, HIV or AIDS, and treatment of alcohol/drug abuse). OR
b. my complete health record with the exception of the following information (circle as appropriate):
Mental Health Records
Communicable diseases (including HIV and AIDS)
Alcohol/drug abuse treatment
Other (please specify):_____.

4. In addition to the authorization for release of my PHI described in paragraphs 3a and 3b of this Authorization, I authorize disclosure of information regarding my billing, condition, treatment, and prognosis to the following individual(s):
Name: _____ Relationship: _____
Name: _____ Relationship: _____

5. This medical information may be used by the persons I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

6. This Authorization shall be in force and effect until nine (9) months after my death or _____ (date or event) at which time this authorization expires.

7. 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.

8. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.
9. 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