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 for Patient: _____(print patient name)
I authorize the below named healthcare providers to use and disclose the protected health information described below to the above named patient's health or auto insurance company (3rd party payor), other healthcare professional for the purpose of referral or co-management of the above named patient's health condition, or other individual(s):

(individual seeking the information).____

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:
I authorize the release of the above named patient's complete health record (including records relating to mental healthcare, and treatment of alcohol or drug abuse).

4. This medical information may be used by the person(s) 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 from the initiation of care until:

(CIRCLE ONE)

Indefinitely, until revoked in writing OR Discharge from care OR _____ (date or event), 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 that 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 the above named patient's treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization, though I understand that if I refuse to sign this agreement and wish for care of the above named patient to proceed, that I will be financially responsible for the care received by the patient, as the healthcare provider will be unable to obtain payment from the patient's insurance company without a release of health information.

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.

_____	_____	_____
Signature of patient, parent/guardian or personal representative	Printed name of patient, parent/guardian or personal representative, and his/her relationship to patient	Date

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