

## 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 (check one)
  - a.  from (date) \_\_\_\_\_ to (date) \_\_\_\_\_ OR
  - b.  all past, present and future periods.
3. I hereby authorize the release of PHI as follows (check 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*  
(check 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 \_\_\_\_\_  
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: \_\_\_\_\_