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# HIPAA Privacy Authorization Form
# Release of Information

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**

I authorize _____ (healthcare provider) to use and disclose the protected health information described below to _____ (individual/agency 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.

c. Any records pertaining to reason for referral

**3. Extent of Authorization (to be completed only if transferring)**

a. I authorize the release any and all health records (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of substance abuse).

b. I authorize the release of my complete health record with the exception of the following information:

___ Mental health records
___Communicable diseases (including HIV and AIDS)
___Substance abuse treatment
___Other (please specify)_____

4. 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.

5. This authorization shall be in force and effect for 1 year from the date of signature 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 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 my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.
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.

Name of Patient: _____ DOB: _____

Signature of patient or guardian: _____

Printed Name of patient or guardian: _____

Date: _____

**Please note: There will be a minimum charge of $25.00 for requests for entire records.**