Patient Name: _____ Patient Number: _____ DOB: _____

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

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

_____(individual/organization seeking the information).

3. Extent of Authorization

☐ I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).

OR

☐ I authorize the release of the following information:

- ☐ Treatment plan
- ☐ Communicable diseases (including HIV and AIDS)
- ☐ Financial/payment history
- ☐ Results of ASI/MV or other assessments
- ☐ Medication--prescription/dosing history
- ☐ Progress notes
- ☐ Urinalyses results
- ☐ Participation levels/rates in counseling
- ☐ Alcohol/drug abuse treatment
- ☐ Other (please specify):

This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, determination of appropriateness for a given course or treatment or other purposes as I may direct.

4. This authorization shall be in force and effect until _____(date or event), at which time this authorization expires (Not to exceed one year from the signature date).

5. 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.

_____ _____ _____

Signature of patient or personal Representative Date

_____

Printed Name of patient or personal representative

_____

If signed by a personal representative, relationship to the patient