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HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

Print Name of Patient(s): _____

Date of Birth: _____

I. My Authorization

I authorize the following party: _____ to release the following health information.

☐ - All of my health information ☐ - My health information from _____ (date) to _____ (date)

☐ - My health information relating to the following condition(s): _____

The above party may disclose this health information to the following recipient:

Name (or title) or organization: _____

Address _____

City _____ State _____ Zip _____

Phone _____ Fax _____ Email _____

II. My Rights

I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission. I may not be able to revoke this authorization if its purpose was to obtain insurance. In order to revoke this authorization, I must do so in writing and send it to the appropriate disclosing party. I understand that uses and disclosures already made based upon my original permission cannot be taken back.

III. If the patient is a **minor** or unable to sign, please complete the following: ☐ - Patient is a minor

Authority of representative to sign on behalf of the patient:

☐ - Parent ☐ - Legal Guardian ☐ - Court Order ☐ - Other: _____

Print Name of Patient or Authorized Representative: _____

Signature of Patient or Authorized Representative:_____

Date: _____