

HIPAA Authorization for Use or Disclosure of Health Information

Patient Name: _____ Date of Birth: _____
Address: _____
City: _____ State: _____ Zip: _____

I, or my authorized representative, authorize _____ to obtain medical records from the following recipient or category of recipient:

Name (or title) and Organization: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____ Email: _____

To use or disclose the following health information: (check one)

Medical Records, including patient histories, medical history and physical exams, office notes (except psychotherapy notes), test results, referrals, consults, billing records, insurance records, and records provided by other health care providers from _____ (date) to _____ (date).

If you would like any of the following sensitive information disclosed, check the applicable box(es) below:

- Alcohol/Drug Abuse Treatment/Referral
- HIV/AIDS-related Treatment
- Sexually Transmitted Diseases
- Mental Health (Other than Psychotherapy Notes)
- Psychotherapy Notes ONLY (by checking this box, I am waiving any psychotherapist-patient privilege)

I expressly consent to the disclosure of all of my medical records indicated above.

The purpose of this authorization is: (check all that apply)

- At my request
- To authorize the using or disclosing party to communicate with me for marketing purposes when they receive payment from a third party to do so.
- To authorize the using or disclosing party to sell my health information. I understand that the seller will receive compensation for my health information and will stop any future sales if I revoke this authorization.
- Other: _____

This authorization ends one year from the date of signature below.

In accordance with applicable state law and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards, I understand and agree that:

This authorization may include information relating to alcohol and drug abuse, mental health treatment, psychotherapy notes) and confidential HIV related information only if I checked where indicated above. In the event the health information described above includes any of these types of information, and I check the applicable box, I specifically authorize the release of such information to the recipient identified above.

I have the right to revoke this authorization, in writing, at any time, except where action has been taken based upon my authorization. In order to revoke this authorization, I must do so in writing and send it to the appropriate disclosing party.

It is possible that information used or disclosed with my permission may be re-disclosed by the recipient and is no longer protected by the HIPAA Privacy Standards or state law. If I am authorizing the release of alcohol or drug treatment, mental health treatment, psychotherapy notes, or HIV related information, the recipient is prohibited from re-disclosing such information or using the disclosed information for any other purpose without my authorization, unless permitted to do so under federal or state law.

Signing this authorization is voluntary. My treatment by any party, payment, enrollment in a health plan, or eligibility for benefits may not be conditioned upon my signing of this authorization (unless treatment is sought only to create health information for a third party or to take part in a research study).

I will receive a copy of this authorization after I have signed it. A copy of this authorization is as valid as the original.

Patient/representative signature: _____ Date: _____
If not patient, name of person signing: _____
Relationship or authority to sign for patient: _____