HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Date: _____
DATE

I. **THE PATIENT**. 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.

Patient's Name: _____
PATIENT'S NAME

Date of Birth: _____
DOB

Social Security Number: _____
SSN

II. **AUTHORIZATION**. I authorize _____
AUTHORIZED PARTY'S NAME

("Authorized Party") to use or disclose the following: (circle one)

- All of my medical-related information.

- My medical information ONLY related to: _____
MEDICAL CONDITION

- My medical-related information from _____ to _____
DATE DATE

- Other: _____
OTHER

Hereinafter known as the "Medical Records."

III. **DISCLOSURE**. The Authorized Party has my authorization to disclose Medical Records to: (circle one)

- Any party that is approved by the Authorized Party.

- ONLY the following party:

Name: _____
NAME

Address: _____
ADDRESS

Phone: _____ Fax: _____
PHONE FAX

E-Mail: _____
EMAIL

IV. **PURPOSE**. The reason for this authorization is: (circle one)

- **General Purpose**. At my request (general).

- **To Receive Payment**. To allow the Authorized Party to communicate with me for marketing purposes when they receive payment from a third party.

- **To Sell Medical Records**. To allow the Authorized Party to sell my Medical Records. I understand that the Authorized Party will receive compensation for the disclosure of my Medical Records and will stop any future sales if I revoke this authorization.

- **Other**: _____
OTHER

V. TERMINATION. This authorization will terminate: (circle one)

- Upon sending a written revocation to the Authorization Party.

- On the following date: _____
DATE

- Other: _____
OTHER

VI. ACKNOWLEDGMENT OF RIGHTS.

I understand that I have the right to revoke this authorization, in writing and at any time, except where uses or disclosures have already been made based upon my original permission. I might not be able to revoke this authorization if its purpose was to obtain insurance.

I understand that uses and disclosures already made based upon my original permission cannot be taken back.

I understand that it is possible that Medical Records and information used or disclosed with my permission may be re-disclosed by a recipient and no longer protected by the HIPAA Privacy Standards.

I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create Medical Records for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization.

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

Signature of Patient: _____ Date: _____

Print Name: _____

(IF THE PATIENT IS UNABLE TO SIGN, USE THE SIGNATURE AREA BELOW)

The patient is unable to sign due to: (circle one)

- **Being a Minor**. Patient is _____ years old and considered a minor under state
AGE

law.

- **Being Incapacitated**. Patient is incapacitated due to:

_____
DESCRIBE PATIENT CONDITION

- **Other**: _____
OTHER

Signature of Representative: _____ Date: _____

Print Name: _____

Relationship to Patient: Parent Spouse Guardian Other: _____
DESCRIBE PATIENT CONDITION

ADDITIONAL CONSENT FOR CERTAIN CONDITIONS

I. SENSITIVE INFORMATION. This medical record may contain information about physical or sexual abuse, alcoholism, drug abuse, sexually transmitted diseases, abortion, or mental health treatment. Separate consent must be given before this information can be released.

(circle one)

- **I consent** to have the above information released.

- **I <u>do not</u> consent** to have the above information released.

Signature of Patient: _____ Date: _____

Print Name: _____

II. HIV/AIDS. This medical record may contain information concerning HIV testing and/or AIDS diagnosis or treatment. Separate consent must be given to have this information released.

(circle one)

- **I consent** to have the above information released.

- **I <u>do not</u> consent** to have the above information released.

Signature of Patient: _____ Date: _____

Print Name: _____