

HIPAA AUTHORIZATION FORM

Name _____

Address _____

Patient's Date of Birth _____

City, State Zip Code _____

Patient's Telephone Number _____

I hereby authorize use or disclosure of protected health information about me as described below.

1. The following specific person/class of person/facility is authorized to use or disclose information about me:

2. The following person (or class of persons) may receive disclosure of protected health information about me:

His/her/its Name _____

Address _____

City, State Zip Code _____

3. The specific information that should be disclosed is (please give dates of service if possible):

UNLESS YOU SIGN HERE, NO INFORMATION ABOUT ALCOHOL/SUBSTANCE ABUSE, HIV/AIDS, OR MENTAL HEALTH WILL BE DISCLOSED:

YES, DISCLOSE THIS INFORMATION * _____

NO, DO NOT DISCLOSE THIS INFORMATION * _____

4. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations.

5. I may revoke this authorization by notifying _____ in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.

6. My purpose/use of the information is for _____.

7. This authorization expires on _____, 200____, OR upon occurrence of the following event that relates to me or to the purpose of the intended use or disclosure of information about me: _____.

FEES FOR COPIES: Federal and state laws permit a fee to be charged for the copying of patient records. This facility has contracted with HealthPort to make copies. You may be required to pre-pay for the copies; if not, then your copies will be mailed along with an invoice. THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING – note that signature is required in two places. *

Signature of Individual*
(The person about whom the information relates)
OR, if applicable –

Date of Individual's Signature

Date of Birth or Social Security Number

Signature of Guardian* or Personal Representative of Patient's Estate

Date of Guardian's/Personal Representative's Signature

Description of Authority to Act for the Individual

A copy of this completed, signed and dated form must be given to the Individual or other signator.

Official Use Only		
_____ Received	_____ Processed By	_____ Log #