HIPAA COMPLIANT AUTHORIZATION

Patient name: _____ Date of Birth: _____

Previous name: _____

I. Authorization

You may use or disclose the following health care information (check all that apply):

- ❑ All health care information in my medical record
- ❑ Health care information in my medical record relating to the following treatment or condition:

  _____
- ❑ Health care information in my medical record for the dates(s): _____
- ❑ Other (e.g., x rays, bills), specify date(s): _____

You may use or disclose the following health care information regarding testing, diagnosis, and treatment, should it be found in my records, only if checked below:

- ❑ HIV (AIDS virus)
- ❑ Sexually transmitted diseases
- ❑ Psychiatric disorders/mental health
- ❑ Drug and/or alcohol use

You may disclose this health care information to:

Name (or title) and organization or category of persons (i.e. all treating physicians, etc.): _____

_____

Address (optional): _____ City: _____State: ___ Zip: _____

Reason(s) for this authorization (check all that apply):

- ❑ At my request
- ❑ Other (specify) _____

This authorization ends:

- ❑ On (date): _____
- ❑ When the following event occurs: _____
- ❑ In 90 days from the date signed (if disclosure is to a financial institution or an employer of the patient for purposes other than payment)

II. My Rights

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment). However, I do have to sign an authorization form:

- To take part in a research study or
- To receive health care when the purpose is to create health care information for a third party.

I may revoke this authorization in writing. If I did, it would not affect any actions already taken by the physician based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. Two ways to revoke this authorization are:

- Fill out a revocation form.
- Write a letter to the physician.

Once health care information is disclosed, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

_____	_____
Patient or legally authorized individual signature	Date Time
_____	_____
Printed name if signed on behalf of the patient	Relationship (parent, legal guardian, personal representative)