

HIPAA AUTHORIZATION FORM

Note: This is NOT a form to be simply adopted and used without further review. It is not endorsed by anyone and is not to be construed as legal advice. It is not necessarily in compliance with what is additionally required under any particular provider's state law. Each facility should consult with its legal counsel regarding finalizing an authorization form.

INDIVIDUAL'S NAME (please print): _____ DATE OF BIRTH: _____

INDIVIDUAL'S ADDRESS _____

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

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

2. The following person (or class of persons) may receive disclosure of protected health information about me: His/her/its name and address: _____ (B)

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

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. (I)

5. I may revoke this authorization by notifying _____ in writing of my desire to revoke it. (II) However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions. (III) I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization (OPTIONAL)

6. My purpose for/intended use of the information is _____ (D)

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: _____ (E)

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.

_____(F)_____(G)_____(H)_____
Signature of Individual Date of Individual's Signature Date of Birth or Social Security Number
(The person about whom the information relates)

OR, if applicable –

_____(F)_____(H)_____
Signature of Guardian or Date of Guardian's/Personal Description of Authority to Act for
Personal Representative of Patient's Estate Representative's Signature the Individual

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