HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Date: _______________, 20____

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: _________________________
Date of Birth: _______________, 20____
Social Security Number: _____-____-_____

II. **AUTHORIZATION.** I authorize _________________________ ("Authorized Party") to use or disclose the following: (check one)

☐ - All of my medical-related information.
☐ - My medical information ONLY related to: _________________________.
☐ - My medical-related information from _______________, 20____ to _______________, 20____.
☐ - Other: ____.

Hereinafter known as the "Medical Records."

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

☐ - Any party that is approved by the Authorized Party.
☐ - ONLY the following party:
Name: _________________________
Address: ____
Phone: (____) ____-______ Fax: (____) ____-______
E-Mail: _________________________

IV. **PURPOSE.** The reason for this authorization is: (check 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:** ____.

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

☐ - Upon sending a written revocation to the Authorization Party.
☐ - On the following date: _______________, 20____.
☐ - 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: (check one)

☐ - **Being a Minor**. Patient is ____ years old and considered a minor under state law.

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

☐ - **Other**: ____.

Signature of Representative: ___________________________ Date: ___________________

Print Name: _________________________

Relationship to Patient: ☐ Parent ☐ Spouse ☐ Guardian ☐ Other: ____________________.