HIPAA Authorization Form

Name: _____

Address: _____

_____

_____

Date of Birth: _____ Social Security Number: _____

Identification Number: _____

Telephone: ( ) _____ E-mail: _____

I authorize the use or disclosure of my protected health information as described below (and will complete a separate authorization if this authorization involves psychotherapy notes):

A. My protected health information will be used or disclosed for the following purposes [please name and explain each purpose and the type of information to be used]:

_____
_____
_____
_____

B. I authorize the following persons (or class of persons) or organizations to make the requested use or disclosure of my protected health information:

_____
_____
_____

C. I authorize the following persons (or class of persons) or organizations to receive my protected health information:

_____
_____
_____

I understand that the use or disclosure of the requested information in this authorization will/will not result in direct or indirect compensation to [covered entity] from a third party.

If I have any questions about this authorization, I may contact _____ at ( ) ___-____, who will provide me with more information about this authorization, or about [covered entity]'s privacy practices.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to [Name and address of contact person]. I also understand that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my protected health information have acted in reliance upon this authorization.

I understand that I do not have to sign this authorization and may, in fact, refuse to do so.

I may inspect or copy the protected health information sought to be used or disclosed in this authorization, as permitted by the federal privacy regulations.

I understand that [name of covered entity] [may/may not] condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization.

I understand that if the organization or person authorized to receive this information is not required to comply with the federal privacy regulations, the released information may be re-disclosed and would no longer be protected.

This authorization expires on [list specific date or event].

I certify that I have received a copy of this authorization.

_____ _____

Signature of Individual or Personal Representative Date

_____

Name of Individual or Personal Representative

_____

Description of Personal Representative's Authority

Provide a copy to the individual