



HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) AUTHORIZATION

SECTION A: Individual authorizing use and/or disclosure

Name: _____

Address: _____

Telephone: _____ Member(Employee)Identification Number: _____

SECTION B: The use and/or disclosure being authorized.

Protected Health Information (PHI) To Be Used and/or Disclosed: (Specifically describe the PHI to be used and/or disclosed)

Name of Patient _____

Name of Providers/Facilities _____

Dates of Service(s) _____

Total Billed _____

Check if this authorization is for psychotherapy notes

If this authorization is for psychotherapy notes, you must *not* use it as an authorization for any other type of protected health information (PHI).

Entities or Persons Authorized to Use or Disclose: (Name or specifically describe the persons and/or organizations [or the classes of persons and/or organizations], including us, who are authorized to make use of and/or to disclose the PHI described above.)

Entities or Persons Authorized to Receive: (Name or specifically identify the persons and/or organizations [or the classes of persons and/or organizations], including us, who are authorized to receive, and subsequently use and/or disclose the PHI described above.)

Purpose of this Authorization:

At request of individual

For the following purposes: _____

No Conditions. This authorization is voluntary. We will not condition your enrollment in a health plan, eligibility for benefits or payment of claims on giving this authorization.

Effect of Granting This Authorization: The PHI used or disclosed may be subject to re-disclosure by the recipient, in which case it may no longer be protected under the HIPAA Privacy Rule.

What course of action are you seeking? Please provide details. Use additional pages if necessary.

SECTION C: Expiration and Revocation.

Expiration: This authorization will expire (complete one):

- On ____/____/____
- On occurrence of the following event (which must relate to the individual or to the purpose of the use and/or disclosure being authorized):

Right to Revoke: I understand that I may revoke this authorization at any time by giving written notice of my revocation to the Contact Office listed below. I understand that revocation of this authorization will not affect any action you took in reliance on this authorization before you received my written notice of revocation.

Contact Office: _____

Telephone: _____ Fax: _____

Address: _____

INDIVIDUAL'S SIGNATURE.

I, _____, have had full opportunity to read and consider the contents of this authorization, and I understand that, by signing this form, I am confirming my authorization of the use and/or disclosure of my protected health information, as described in this form.

Print Name: _____

Signature: _____ Date: _____

If this authorization is signed by a personal representative on behalf of the individual, complete the following:

Personal Representative's Name: _____

Signature: _____ Date: _____

Relationship to Individual: _____

YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION AFTER YOU SIGN IT.