



## 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.**

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**SECTION C: Expiration and Revocation.**

Expiration Date: If not previously revoked, this authorization will terminate on the earliest of the following dates (check one):

- The date my coverage ends (only if disclosure requested by insurance company); or
- One year from the signature date below; or
- Upon the following date, event or condition (within the one-year time frame):

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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.**