HIPAA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information (Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 & 164)

1. Authorization

I authorize Dr. _____ (Center for Dermatology) to use and disclose the protected health information described below to _____

_____

(individual/entity seeking the information, ie family member, physician, hospital; ok to list multiple)

2. Effective Period - This authorization for release of information covers the period of healthcare for:
   a. ☐ Present to 1 year from today.
   b. ☐ All past, present, and future periods.
3. Extent of Authorization

a. ☐ I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).

b. ☐ I authorize the release of my complete health record with the exception of the following information:

   ☐ Mental Health records

   ☐ Communicable diseases (including HIV and AIDS)

   ☐ Alcohol/drug abuse treatment

   ☐ Other (please specify): _____

4. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing, or claims payment, or other purposes as I may direct.
5. This authorization shall be in force and effective until I specify otherwise, at which time, authorization expires.
6. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.
7. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.
8. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____

Signature of patient or personal representative Date

_____

Printed name of patient or personal representative and his/her relationship to patient