

HIPAA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information

(Required by the Health Insurance Portability and Accountability Act – 45 CFR Parts 160 and 164)

1. I hereby authorize St. Joseph Heritage Medical Group to use and/or disclose the protected health information described below to _____
[Name of Person(s) and Relationship]
- _____
- [Name of Person(s) and Relationship]
- _____
- [Name of Person(s) and Relationship]

2. Authorization for Release of Information. Covering the period of health care from

_____ to _____ **OR** all past, present and future periods:

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

OR

b. I hereby **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): _____

3. This authorization shall be in force and effect until _____, at which time this authorization expires.
[Date or Event]

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. 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.

6. I understand that my treatment, payment, enrollment or eligibility for benefits will not be conditioned on whether I sign this authorization.

7. 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

Print Name of Patient or Personal Representative

Relationship to Patient