HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

Print Name of Patient:				
Date of Birth:	SSN:			
I. My Authorization				
	g using or disclosing party:		M	
To use or disclose th	e following health information	ı: (check one)		
□ - All of my health info	ormation			
□ - My health informati	ion relating to the following treati	ment or condition:		
☐ - My health informati	ion covering the period from	(date) to	_ (date)	
□ - Other:				
The above party may	disclose this health informati	on to the following recipient:		
Name (or title) and organization				
Address				
	State			
Phone	Fax	Email		
The purpose of this a	uthorization is: (check all that	apply)		
□ - At my request				
□ - Other:			······································	
	sing or disclosing party to commu ment from a third party to do so.		ırposes	



\Box - To authorize the using or disclosing party to sell my health information. I understand that the seller will receive compensation for my health information and will stop any future sales if I revoke this authorization.
This authorization ends: (check one)
□ - On (date)
□ - When the following event occurs:
II. My Rights
I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission. I may not be able to revoke this authorization if its purpose was to obtain insurance. In order to revoke this authorization, I must do so in writing and send it to the appropriate disclosing party.
I understand that uses and disclosures already made based upon my original permission cannot be taken back.
I understand that it is possible that information used or disclosed with my permission may be redisclosed by the recipient and is no longer protected by the HIPAA Privacy Standards.
I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create health information for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization.
I will receive a copy of this authorization after I have signed it. A copy of this authorization is as valid as the original.
Signature of Patient:
Date:
If the patient is a minor or unable to sign, please complete the following:
□ - Patient is a minor: years of age
□ - Patient is unable to sign because:
Signature of Authorized Representative:
Date:



Print Name of Authorized Representative:
Authority of representative to sign on behalf of the patient:
□ - Parent □ - Legal Guardian □ - Court Order □ - Other:
III. Additional Consent for Certain Conditions
This medical record may contain information about physical or sexual abuse , alcoholism , drug abuse , sexually transmitted diseases , abortion , or mental health treatment . Separate consent must be given before this information can be released.
\square - I consent to have the above information released.
\square - I do not consent to have the above information released.
Signature of Patient or Authorized Representative:
Date: Time:
IV. Additional Consent for HIV/AIDS
This medical record may contain information concerning HIV testing and/or AIDS diagnosis o treatment . Separate consent must be given to have this information released.
□ - I consent to have the above information released.
□ - I do not consent to have the above information released.
Signature of Patient or Authorized Representative:
Date: Time:

