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| HIPAA Authorization Form |
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| **AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION** |
| Please complete **all sections** of this HIPAA Authorization Form. If any sections are left blank, this form will be invalid. Use N/A if not applicable. (Page 1 of 2) |
|  |
| **Section 1 – Patient/Plan Member Information** |  |
| Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Middle Name: \_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| Reference Nº: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | City/State/ZIP:\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| **Section 2 - Individual/Organization Authorized by Signatory to Disclose PHI** |  |
| Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | City/State/ZIP:\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| **Section 3 - Individual/Organization Authorized by Signatory to Receive PHI** |  |
| Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| Relationship to Patient/Plan Member:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | City/State/ZIP:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| **Section 4 - Authorization Expiration Event or Date** |  |
| Unless otherwise revoked by the patient/plan member, this authorization for the release of PHI to the above-named individual/organization will expire on the event or date specified below. Enter N/A in both fields if the release is ongoing.  |  |
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| Expiration Event: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Expiration Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| **Section 5 – Health Information to be Disclosed - General**  |  |
| I authorize the following Protected Health Information to be disclosed: |  |
| q Medical Records | q Dental Records | q Other Non-Specific |  |
| If Other Non-Specific, provide details:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| **Section 6 – Health Information to be Disclosed – Specific** |  |
| I authorize the following Protected Health Information to be disclosed: |  |
| q Communicable Diseases | Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| q Reproductive Health | Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| q HIV Test Results | Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| q Mental Health Records \* | Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| q Substance Use Disorder | Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| q Other | Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| If "Other", provide details: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| **\* Requests for psychotherapy notes require a separate HIPAA Authorization Form and may not be combined with any other request.** |  |
|  |
| q Psychotherapy Notes | Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
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| **AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION** |
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| **Section 7 - Purpose of the Release or Use of Health Information** |  |
| q Health Care q Research | q Marketing |  q Sale q Legal |  |
| q Other (please specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Note: The sale of PHI authorized by this HIPAA Authorization Form will result in remuneration to the party specified in Section 2. |  |
| **Section 8 - Authorization Information** |  |
| I understand the following: |  |   |  |
| 1. I authorize the use or disclosure of Protected Health Information as described above for the purpose indicated until such event or time as specified in Section 4. |  |
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| 2. I have the right to revoke this authorization. To do so I understand I must submit my revocation in writing to the party specified in Section 2. The revocation will prevent further disclosure of my health information from the date of receipt. |  |
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| 3. I am signing this authorization voluntarily and understand my entitlement to health care or health plan benefits will not be affected if I do not sign this HIPAA Authorization Form. |  |
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| 4. If the party specified in Section 3 is not a HIPAA Covered Entity or Business Associate as defined in 45 CFR §160.103, the disclosed health information may no longer be protected by federal and state privacy regulations. |  |
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| 5. I have a right to receive a copy of this HIPAA Authorization Form. |  |
| 6 (if applicable). My substance abuse disorder records are protected under the federal regulations governing the Confidentiality of Substance Use Disorder Patient Records and cannot be redisclosed without my written authorization. |  |
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| **Section 9 - Additional Conditions that Apply to this HIPAA Authorization Form** |  |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| **Section 10 - Signature by or on Behalf of Patient/Plan Member** |  |
| Name of Patient/Plan Member (Print):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| Name of signatory if not patient/plan member: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| Authority to sign on behalf of patient/plan member: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| Name of translator (if applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| Signature of translator (if applicable)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |