

HIPAA Authorization to Disclose Protected 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.*

Patient Name: _____ **Patient Date of Birth:** _____

My Authorization

I authorize the following individual or medical practice: _____

Health Information to be used or disclosed: (Check one)

- ☐ All of patients health information
- ☐ Health information covering dates from _____ to _____
- ☐ Health information relating to following treatment or condition:

- ☐ Other: _____

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 re-disclosed by the recipient and is no longer protected 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 understand that I can receive a copy of this authorization after I have signed it at any time I request a copy.

Signature of Patient _____ Date: _____ Time: _____

Name of Witness: _____ Title: _____

Signature of Witness _____ Date: _____ Time: _____

Patient Sticker

Last _____
First _____
DOB _____
FIN _____