

## 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 all medical service sources and health care providers to use and/or disclose the protected health information (PHI) described below to my agent identified in my durable power of attorney for health care named: \_\_\_\_\_
2. Authorization for release of PHI covering the period of health care (check one):  
 From (date): \_\_\_\_\_ To (date): \_\_\_\_\_  
 All past, present and future periods.
3. I hereby authorize the release of PHI as follows (check one):  
 My complete health record (including records relating to mental health care, communicable diseases, HIV or AIDS, and treatment of alcohol/drug abuse).  
 My complete health record, with the exception of the following information (check as appropriate):  
 Mental health records  
 Communicable diseases (including HIV and AIDS)  
 Alcohol/drug abuse treatment  
 Other (please specify): \_\_\_\_\_
4. In addition to the authorization for release of my PHI described in section 3 of this authorization. I authorize disclosure of information regarding my billing, condition, treatment and prognosis to the following individual(s):  
Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Name: \_\_\_\_\_ Relationship: \_\_\_\_\_
5. This medical information may be used by the persons I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.
6. This authorization shall be in force and effect until nine (9) months after my death or: (date or event) at which time this authorization expires.
7. 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.
8. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.
9. 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.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_