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)

Authorization for release of Personal Health Information covering the period of health care (check one):

From (date) _____ - To (date) _____

OR

All past, present and future periods.

In addition to the authorization for release of my protected health information, I authorize disclosure of

information regarding my billing, condition, treatment and prognosis to the following individual(s):

Name _____Relationship _____

Name _____Relationship _____

Name _____Relationship _____

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. 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. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization. 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's Name: _____

Signature: _____Date: _____

If patient has a Power of Attorney:

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: _____.