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HIPPA RELEASE OF INFORMATION

Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164

I authorize _____(Healthcare Provider) to use and disclose the protected health information of _____ (Patient Name and Date of Birth) described below to_____(Individual Seeking the Information).

Effective Period

This authorization for release of information covers the period of healthcare from

- ☐ Date range _____ to_____

OR

- ☐ All past, present, and future periods

Extent of Authorization

- ☐ I authorize the release of my computer health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).

OR

- ☐ I authorize the release of my computer health records with the exception of the following information:
  - ☐ Mental health records
  - ☐ Communicable diseases (including HIV and AIDS)
  - ☐ Alcohol/drug abuse treatment
  - ☐ Other (please specify) _____

1. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payments, or other purposes as I may direct.
2. This authorization shall be in force and effect until_____(date or event), at which time this authorization expires.
3. 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.
4. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.
5. 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.

_____ _____

Authorized Signature Date

_____

Print Name