HIPAA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information
(Required by the Health Insurance Portability and Accountability Act- 45 CRG 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 _____.
(Patient Name)

2. Authorization for release of PHI covering the period of health care (check one):
   - ❑ a. From (date)_____ -to (date) _____ OR
   - ❑ b. All past, present and future periods.

3. Further, I hereby authorize and give any consent to The Doctor's Office to leave messages on my answering machine/voicemail/e-mail for the following (check all that apply)

Appointment reminders	_____	Prescription Refills	_____	E-mail	_____
Medical Information	_____	Test Results	_____	Text	_____
Insurance/Payment Issues	_____	Mail	_____		

4. In addition to the authorization for release of my PHI described in paragraphs 2 a and 2 b 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.

I understand the 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.

_____ Date:_____
Signature of Patient