

# HIPAA Privacy Authorization Form

\*\*Authorization for Use or Disclosure of Protected Health Information (Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)\*\*

1. I, \_\_\_\_\_ authorize all medical service sources and health care providers to use and/or disclose the protected health information (PHI) described below to my Personal Representative(s) named as follows:

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2. This authorization for release of PHI covers the period of healthcare (check one)

a.  from (date) \_\_\_\_\_ to (date) \_\_\_\_\_. OR

b.  all past, present, and future periods.

3. I hereby authorize the release of PHI as follows (check one):

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

b.  I authorize the release of my complete health record with the exception of the following information:

Mental health records

Communicable diseases (including HIV and AIDS)

Alcohol/drug abuse treatment

Other (please specify): \_\_\_\_\_

4. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

5. This authorization to release information to my Personal Representative will automatically expire two (2) years following the termination of my enrollment with the Health Plan.

6. 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.

7. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

8. 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.

\_\_\_\_\_  
Signature of Member or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed name of patient or personal representative and relationship to Member