HIPAA AUTHORIZATION FORM

1. I hereby authorize the use or disclosure of my protected health information as described below.

Individual: ________________________________ **ID Number:** _________________________

Persons or organizations providing information:

____

____

____

Persons or organizations receiving information:

____

____

____

Description of information to be disclosed (including dates of service): ___________________________

____

____

Describe the purpose or intended use of information:____

____

(Note: "at the request of the individual" is adequate if the individual initiated authorization without a stated purpose.)

2. COMPLETE THIS SECTION IF HEALTHCARE PROVIDER REQUESTED AUTHORIZATION.

Healthcare provider: Will the healthcare provider receive financial or in-kind compensation in exchange for using or disclosing the health information described above? Yes____ No____

Individual: I understand that I get a copy of this form after I sign it. initials:________

3. YES, YOU MAY DISCLOSE INFORMATION ABOUT ALCOHOL/SUBSTANCE ABUSE, HIV/AIDS, OR MENTAL HEALTH: **YES Initial: _________** **NO**, **DO NOT Initial: _________**

4. I understand I have the right to refuse to sign this form and that my refusal will not result in the physician conditioning the provision of Healthcare with two exceptions: 1. Refusal to sign this authorization, if it is for disclosure of information created for research that includes treatment, may result in the physician declining to provide the research-related treatment. 2. Refusal to sign this authorization, if it is for disclosure of information created for the sole purpose of disclosure to a third party, may result in the doctor declining to provide the healthcare which is for the sole purpose of creating protected health information for disclosure to a third party. **Initial: _________**

5. I understand that this authorization will expire on the following date___/___/____(D/MM/YR) or with the following event: ____

6. I understand that I may revoke this authorization at any time by notifying the healthcare provider in writing. The revocation will only be effective from the date it is received in this office and will not apply retroactively. **Initial: _________**

____ ______________________

7. Signature of patient or patient's representative **Date**

Printed name of patient's representative: ____

Relationship to the patient: ____

THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING

Note that signature or initials are required in four places.

A copy of this completed, signed and dated form must be given to the Individual or other signatory.