Model HIPAA Authorization

This document contains a model authorization form as required under the final privacy rules issued by HHS pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This form reflects only the federal requirements under HIPAA and not any additional requirements imposed by states. Unless otherwise noted, all items in this form must be completed.

Please note that this model form does not reflect Federal Substance Abuse Confidentiality Requirements.

Drafted (date)

Model Authorization for Use or Disclosure of Protected Health Information

I authorize the use/disclosure of health information about me as described below.

1. Person(s) or class of persons authorized to use/disclose the information:
_____
_____

2. Person(s) or class of persons authorized to receive the information:
_____
_____

3. Description of information that may be used/disclosed.
_____
_____

4. The information will be used/disclosed for the following purposes: (Note: this item is not required if the disclosure is requested by the patient.)
_____
_____

5. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and no longer protected by these regulations.

6. [If applicable] I understand that the person I am authorizing to use/disclose the information will receive compensation for doing so. (Note: this item is not required if the disclosure is requested by the patient.)

7. I understand that I may refuse to sign this authorization. and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or

copy any information used/disclosed under this authorization. (1'1ote: this item is not required if the disclosure is requested by the patient.)

8. I understand that I may revoke this authorization in writing at any time by _____ except to the extent that action has been taken in reliance on this authorization. This authorization expires [insert applicable date or event].

_____ _____

Signature of Patient or Representative Date

_____

Patient's Name

_____ _____

Name of Personal Representative (if applicable) Relationship to Patient

(A copy of this signed form will be provided to the patient)