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. **Authorization**

I authorize Orthohealing Center (healthcare provider) to use and disclose the protected health information described below to the follow person(s) _____(individual seeking the information).

2. **Effective Period**

This authorization for release of information covers the period of healthcare from the below dates:

_____ to _____ OR □ all past, present, and future periods.

3. **Extent of Authorization**

□ I authorize the release of my complete health record (including records relating to mental healthcare, and treatment of alcohol or drug abuse). □ I authorize the release of my complete health record with the exception of the following:

□ Mental health records

□ 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 shall be in force and effective until date listed in item (2) above, at which time this authorization expires.

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.

_____ _____ _____

Printed name of patient/guardian | Signature of patient/guardian | Date

If all categories declined above, please check below

□ Acknowledgement of Receipt of Notice of Privacy Practices

Signature

I have received a copy of the Privacy Practices for the Orthohealing Center.

_____ _____ _____

Printed name of patient/guardian | Signature of patient/guardian | Date