HIPAA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information
(Required by the Health Insurance Portability and Accountability Act -45 CFR Parts 160 and 164)

1. I hereby authorize *Dr. Emily S. Gausman* to use and/or disclose the protected health information described below to_____ (name of individual, and relationship).
2. Authorization for Release of Information. Covering the period of health care from
   - ☐ _____ to _____

   OR

   - ☐ All past, present and future periods:
     - o a. I hereby authorize the release of my complete health record (including records relating to mental health care, communicable diseases, H1V or AIDS, and treatment of alcohol/drug abuse).
       OR
     - o b. I hereby 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): _____
3. This information may be used by the person I authorize to receive this information for treatment or consultation, billing or claims payment, or other purposes as I may direct.
4. 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.
5. I understand that my treatment, payment, enrollment or eligibility for benefits will not be conditioned on whether I sign this authorization.
6. 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 Patient or Personal Representative)

_____
(Date)

_____
(Relationship to Patient)