PINE BUSH MENTAL HEALTH HIPAA Privacy Authorization Form

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

****1. Authorization****I authorize _____(healthcare provider) to use and disclose the protected health information described below to _____(individual seeking the information).

****2. Effective Period****This authorization for release of information covers the period of healthcare from: (Circle One)

a. _____to _____.**OR b. all past, present and future periods.

****3. Extent of Authorization****a. I authorize the release of my complete health record (including records relating to mental healthcare, communicable disease, HIV or AIDS, and treatment of alcohol or drug use).**OR** b. I authorize the release of my complete health record with the exception of the following information (Circle ones that apply)

- Mental Health records
- Communicable disease (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 shall be in force and effect until _____(date of event), 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 in 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 my no longer be protected by federal or state law.

Signature of patient or personal representative

_____

Printed name of patient or personal representative and his or her relationship to patient

_____

Witness_____Date_____