Republic Family Medicine llc
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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)

I authorize disclosure of information regarding my condition, treatment, prognosis and billing to the following individual(s):

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

I also authorize all medical service sources and health care providers to use and/or disclose my protected health information ("PHI") described below to my agent identified in my durable power of attorney for healthcare named:

_____

Authorization for release of PHI covering the period of health care (check a or b)

a. ( ) from (date) _____/___/_____ - to (date) _____/___/_____

b. ( ) all past, present and future periods.

I hereby authorize the release of PHI as follows: (check a or b)

a. ( ) my complete health record

b. ( ) my complete heath record *with the exception of the following information*:

( ) Mental health records

( ) Communicable diseases (including HIV and AIDS)

( ) Alcohol/drug abuse treatment

( ) Other (please specify): _____

This medical information may be used by the persons I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

This authorization shall be in force and effect until nine (9) months after my death or

_____, (date or event) at which time this authorization expires.

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.

I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

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: _____ **Date:** _____/_____/_____