**Internal Medicine of Chevy Chase**

**HIPAA Privacy Authorization Form**

**Release of Medical records**

\*\*Authorization for Use or Disclosure of Protected Health Information

(Required health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164) \*\*

1**. Authorization:**

I authorize Internal Medicine of Chevy Chase 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ 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, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).

\*\*OR\*\*

□ I 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 (pleasespecify):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

5. This authorization shall be in force and effect until\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(date or 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 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.

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Signature of patient or personal representative

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Printed name of patient or personal representative and his or her relationship to patient. Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_