Island Ob/Gyn
For A Woman's Best Health

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 hereby authorize all medical service sources and health care providers to use and/or disclose my protected health information (''PHI'') described.

Authorization for release of PHI covering the period of health care:

- ❖ All past, present and future periods.

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

Name _____ Relationship _____
Name _____ Relationship _____
Name _____ Relationship _____

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.

_____ DOB: _____
Patient's Name

_____ Date: _____
Signature of Patient

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