

Authorization for Use or Disclosure of Protected Health Information Required by the Health Insurance Portability and Accountability Act

I authorize _____ (health care practitioner) to use and disclose the protected health information described below to _____ This authorization for release of information covers the period of healthcare from _____ for claim _____

I authorize the release of my complete medical record including all intake forms, chart notes and billing records.

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.

This authorization shall be in force and effect until conclusion of treatment on this claim, 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 or Personal Representative Date

Printed Name of Patient or Personal Representative and relationship to patient