HIPAA AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Medical Information Holder: ____ Attention: ______________________________
Address: ____
City, State, Zip: ____
Phone: ______________________ Fax: _________________________ E-mail: _________________________

Patient name: ____
Address: ____
City, State, Zip: ____
Phone: ______________________ Fax: _________________________ E-mail: _________________________
Date of Birth: ___/___/________ Patient ID Number: _________________________

Authorized Information Recipient(s):
Name: ____ Attention: ________________________
Address: ____
City, State, Zip: ____________________________________
Phone: ______________________ Fax: _________________________ E-mail: _________________________
Purpose: ____ Expiration date: ___________________
(personal, worker's compensation, insurance, benefits, reimbursement, medical, further evaluation, treatment, legal, verification, other)

Name: ____ Attention: ________________________
Address: ____
City, State, Zip: ____________________________________
Phone: ______________________ Fax: _________________________ E-mail: _________________________
Purpose: ____ Expiration date: ___________________

GENERAL AUTHORIZATION: This release applies to any individually identifiable health information (Protected Health Care Information) governed and protected by the Health Insurance Portability and Accounting Act of 1996 (HIPAA), as amended, and under the rules and regulations thereunder. I, the undersigned patient or legal representative, hereby authorize the above named Medical Information Holder to use, review, give, disclose and release the health, medical, and mental health information and related records for the patient named above, and as specified below, to the recipient(s) named above. Method of release shall be pertinent to the need and may include photocopies, photographs, fax copies, scanned copies, postal mail, express mail, computer files, e-mail, personal review, inspection, audio, telephone, video, electronic, or verbal communication.

SPECIFIC AUTHORIZATION: I specifically authorize the release of information regarding the following types of records, services, treatment, care and the types of medical conditions, restricted to the following dates:

AUTHORIZATION FOR RELEASE OF INFORMATION OF CERTAIN DATES:
(Check one date range below)
___ For all products, services, treatment, patient care, benefits received on specific date: _________
___ For all products, services, treatment, patient care, benefits received from beginning date: _________ to ending date: _________
___ For all products, services, treatment, patient care, benefits received during the last _________ years.
___ For entire patient history on file

AUTHORIZATION FOR RELEASE OF CERTAIN TYPES OF INFORMATION: (Check one of the 3 choices below)

1. **All Information**. If you check this box, any and all information in your file may be released to the recipient(s). If someone is directly involved in reviewing or coordinating your health care or benefits, you may want them to have access to all of your information.
___ **All information** related to the provision of and payment for my health care benefits or services

2. **Limited to Specific Information Only**. Check this box to indicate that you want to release only the specific information that you select below.
___ Specific information as selected below
___ Only for a specific type of medical condition, service, treatment, or patient care: ____________________________

3. **Psychotherapy Notes** are notes recorded by a mental health professional documenting or analyzing the contents of a conversation during a counseling session. These notes are separated from the rest of the patient's medical record. Psychotherapy notes cannot be combined with an authorization to release any other type of information.
___ **Psychotherapy notes**, recordings and dictation – Federal law requires a separate authorization to use or release psychotherapy notes.

To restrict the release of information to Specific Information Only, check the boxes for the information that you authorize for release:

___ Copy of complete medical records, including correspondence, reports, medication sheets, prescriptions, doctor's orders, visits, supply needs
___ Copy of complete record for outpatient and Emergency Room admissions, Emergency Department (ED) record
___ Copy of complete record for inpatient admissions and hospital chart
___ Discharge summary ___ History and physical exams ___ Consultations ___ Treatment plan ___ Prescriptions

___ X-rays, scans, laboratory records and reports ___ Pathology reports ___ Cardiology reports ___ Neurology reports
___ Radiology reports, films, imaging reports ___ Radiation treatment record ___ EKG ___ EEG

___ Correspondence and reports ___ Operative reports ___ Ambulatory record
___ Admitting Psychiatric Assessment
___ Billing statements, invoices, payment records ___ Insurance policy, application and related records ___ Benefits information

Special permission to authorize release of the information below: **(initials required)**

____ (initials) Mental / Behavioral health record
____ (initials) Psychological evaluations (excludes psychotherapy notes which require separate release)
____ (initials) Psychosocial / Psychiatric information (excludes psychotherapy notes which require separate release)
____ (initials) Neuro-psychological / Psychological testing & evaluations (does not include raw data or psychotherapy notes)
____ (initials) Alcohol / Drug / Substance abuse information – I understand that my chemical dependency records are protected under Federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CRF, Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. Federal regulations require that consent to release alcohol or drug records last no longer than reasonably necessary to serve the purpose for which the release is given.
____ (initials) HIV / AIDS related information
____ (initials) Sexually transmitted disease (STD) information
____ (initials) Physical or sexual abuse information
____ (initials) Genetic information
____ (initials) Other ____

EXPIRATION OR REVOCATION OF AUTHORIZATION

This authorization shall supercede any prior written authorization I have made regarding the use, release and disclosure of my medical information. I may revoke this authorization at any time, by written notice, except to the extent that action has already been taken to comply with it. Unless expressly revoked or otherwise terminated by expiration date listed above, this authorization will automatically expire upon fulfilling the purpose or need for information as specified above, or as limited by law. This authorization shall not be affected by my death, disability or incapacitation.

OTHER TERMS AND CONDITIONS

I understand that if a recipient is not a covered entity under privacy laws and regulations, the information disclosed or used under this authorization may be further disclosed to other parties and is no longer protected by privacy laws and regulations. I do not authorize such secondary disclosure.

I understand that I may inspect or request a copy of the information to be used, released or disclosed.

I understand that my treatment and benefits are in no way conditioned on whether or not I sign this authorization and that I may refuse to sign it.

I understand that I may be charged a reasonable fee for a service charge, copying and postage related to the release of my medical information.

I understand that my authorized representative will be required to provide legal documents to prove their authority to sign on my behalf and may be required to provide proof of identity. If these legal documents have not already been submitted, they are included along with this authorization.

A copy of this authorization (including a facsimile copy, photocopy or email) may be used with the same effectiveness as the original.

SIGNATURE:

Print Patient Name: ____

Patient Signature: ____ Date: ____________________

Authorized representative name: ________________________________ Relationship: ______________________________

(Parent, guardian, conservator, executor, administrator, trustee, power of attorney, agent, patient advocate, other)

Authorized representative signature: ____________________________ Date: ____________________

(Please keep a copy of this form for your records.) Form HIPAA-REL01, 03/27/07