HIPAA AUTHORIZATION FORM

I, ______________________, do hereby authorize use or disclosure of protected health and psychiatric information about myself, Social Security Number ___________________, date of birth, ______________________, as described below.

1. The following specific person or class of persons or facility is authorized to make the requested use or disclosure:

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2. The following person or class of persons may receive disclosure of protected health and psychiatric information about _________________________:

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3. The specific information that should be disclosed is: All medical records, including all diagnostic procedures, prescription records, or any portion thereof, and psychiatric information which may be requested by the above named person(s) concerning any care and treatment provided to me at any time. I also authorize any doctor, pharmacy or representative of the above facility to discuss all aspects of my care and treatment, in person or by phone or email communication, with the person(s) identified above.

4. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations.

5. I may revoke this authorization by notifying ______________________ in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization.

6. This authorization expires on __________________________.

THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING.

This ___ day of __________, 20__.

____
Printed Name: