HIPAA AUTHORIZATION TO
DISCLOSE PROTECTED HEALTH INFORMATION

A. **Patient Identification**

Name: _____ **Date of Birth**: _____
Address: _____ **Phone #:** _____
_____,_____ _____

B. **Definitions**

i. Covered Entity – Covered entities are defined by HIPAA as health plans, health care clearinghouses, and health care providers who conduct certain financial and administrative transactions electronically. These entities are bound by the privacy standards of HIPAA even if they contract with other to perform some of their essential functions.

ii. HIPAA – The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") establishes standards and procedures that covered entities must follow when disclosing a patient's protected health information.

iii. Protected Health Information – Under HIPAA, protected health information is considered to be individually identifiable information relating to the health status of an individual, the provision of healthcare, or individually identifiable information that is created, collected, or transmitted by a HIPAA-covered entity in relation to payment for healthcare services. Protected health information includes, but is not limited to, diagnoses, treatment information, medical test results, prescription information, birth dates, gender, ethnicity, contract and emergency contact information.

C. **Authorization**

I, _____, authorize and direct any physician, other health care professional, dentist, health plan, hospital, clinic, laboratory, pharmacy or other covered health care provider, any insurance company and the Medical Information Bureau or other health care clearinghouse that has provided treatment or services to me, or that has paid for or is seeking payment from me for such services (collectively, the "Providers"), to release and disclose the Protected Health Information described herein to the following party(ies) as my agent, to be treated as I would with respect to my rights regarding the use and disclosure of my protected health information:

Name: _____ **Relation:** _____
Address: _____
_____,
_____ _____

D. **Limitations on Authorization**

i. Extent of Authorization

I authorize the release of my protected health information, including: history/physical exam results, progress notes, physician's orders, patient allergies, consultation reports, discharge summaries, pathology reports, operative reports, emergency room record, laboratory reports, x-rays, imaging reports, abstracts or summaries, and the contents of medical records. The release specifically excludes the following:

- information relating to the treatment of HIV/AIDS or other sexually transmitted diseases;
- information relating to the treatment of mental illness;
- information relating to the treatment and diagnosis of drug or alcohol abuse;

ii. Period of Health Care Covered by the Authorization

This authorization of the release of my protected information covers all past, present and future protected health information.

iii. Electronic Disclosure

E. **Reason for Disclosure**

The reason the protected health information is being disclosed is: _____

F. **Effective Time Period**

This authorization will be in effect until the earlier of one year after the occurrence of my death, or until I expressly revoke authorization.

G. **Patient Rights and Acknowledgments**

i. This release does not affect my ability to obtain treatment, payment, or eligibility for benefits.

ii. I recognize that I have the right to inspect or copy the protected information held by covered entities.

iii. I understand that I have the right to revoke this authorization, in writing, at any time, except to the extent a provider has acted in reliance on it.

iv. 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.

The date this form is signed is the effective date of this authorization.

Date: _____

By: _____

Patient Name: _____

Phone Number: _____

HIPAA Release

Instruction Sheet

What is it?

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) establishes standards and procedures that covered entities (which includes health plans, healthcare clearinghouses, and healthcare providers that transmit specific information electronically) must follow when disclosing a patient's protected health information.

This Release complies with the procedures established by HIPAA and allows a patient to authorize the release of their medical information to another person or entity.

Why would I use it?

If you are seeking to authorize the disclosure of your protected information, this form is designed for you.

Alternate Names

HIPAA Authorization
Medical Release

What do I do with this HIPAA release?

1) Read

- Read the HIPAA release document thoroughly and make sure all of the information is correct.

2) Execute

- When satisfied with the contents of the HIPAA release, the patient, or the patient's representative, must sign and date the release.
- Additionally, if information related to the treatment of HIV/AIDS, STD's, mental illness, and drug/alcohol treatment is being released, the corresponding blanks should be initialed in Section D of the release.

3) Post-Execution

- After executing the HIPAA release, retain the original copy for your records. If someone else will be recieving the medical records, they should receive a copy of the release.
- Each covered entity that will be releasing the patient's health information will need to be presented with a copy of this document.