HIPAA PRIVACY AUTHORIZATION FORM

Authorization for Use or Disclosure of Protected Health Information

(Required by the Health Insurance Portability and Accountability Act- 45 CPR Parts 160 and 164)

1) Authorization form release of PHI Covering the period of health care (check box)

❏ **All past, present and future periods.**

2) In addition to the authorization for release of my PHI, I authorize disclosure of information regarding my billing, condition, treatment, and prognosis to the following individual(s):

Name____**Relationship**________________________

Name____**Relationship**________________________

Name____**Relationship**________________________

This authorization shall be in force and effect until nine(9) months after my death or Authorization Pulled , (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 the authorization or if the authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

Patient name printed ______________________________

Signature of Patient: _________________________________**Date:** __________________________