HIPAA Privacy Authorization Form

**Authorization for Use or Disclosure of Protected Health Information (Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)**

1. I, __________________________________________ authorize all medical service sources and health care providers to use and/or disclose the protected health information (PHI) described below to my Personal Representative(s) named as follows:

2. This authorization for release of PHI covers the period of healthcare (check one)
   a. □ from (date)______________ to (date) ______________. OR
   b. □ all past, present, and future periods.

3. I hereby authorize the release of PHI as follows (check one):
   a. □ I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse). OR
   b. □ I authorize the release of my complete health record with the exception of the following information:
      □ Mental health records
      □ Communicable diseases (including HIV and AIDS)
      □ Alcohol/drug abuse treatment
      □ Other (please specify): ____________________________________________

4. 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.

5. This authorization to release information to my Personal Representative will automatically expire two (2) years following the termination of my enrollment with the Health Plan.

6. 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.

7. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

8. 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 Member or Personal Representative   Date

______________________________________________________________
Printed name of patient or personal representative and relationship to Member