HIPAA (Health Insurance Portability and Accountability Act)

Authorization for Use or Disclose Protected Health Information in Compliance with The Privacy Rule
(45 CFR Part 160 and Subparts A and E of Part 164)

Information may be used by the person(s) listed below to receive information regarding medical treatments, consultations, billing, claims, payments, and/or other purposes as I direct. I authorize **Meetinghouse Family Physicians** to use and disclose protected health information to:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Authorization for release of personal health information covering the period of healthcare: (*select one*)

- ☐ From _____/_____/_____ to _____/_____/_____
- ☐ All past, present, and future dates.

I hereby authorize the release of personal health information as follows: (*select one*)

- ☐ My complete health record (mental health, communicable disease, HIV/AIDS, and treatment of alcohol and/or drug abuse).
- ☐ Limited access to (*select all that apply*):
  - ☐ Mental health
  - ☐ Communicable disease (HIV/AIDS)
  - ☐ Drug and/or alcohol abuse and/or treatment
  - ☐ Medications (controlled and non-controlled)

This authorization will be valid for 1 year or 9 months after my death. I understand that I have the right to revoke this authorization in writing at any time. I understand that I am unable to retroactively revoke this authorization. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization. I understand that information used or disclosed to the person(s) listed above will no longer be protected by federal or state law.

Patient Signature: _____

Patient Printed Name: _____

Date of Birth: _____ Today's Date: _____

Patient Legal Representative Signature: _____

Patient Legal Representative Printed Name: _____

Today's Date: _____