# HIPPA Privacy Authorization Form

## Authorization for use or Disclosure of Protected Health Information

(Required by the Health Insurance Portability and Accountability Act – 45C.F.R. Parts 160 and 164)

1) Information may be used by person(s) listed below to receive information regarding medical treatments or consultations, billing/claims, payments, or other purposes as I direct. I authorize Meetinghouse Family Physicians to use and disclose protected health information to:
   Name: _____ Relationship: _____
   Name: _____ Relationship: _____
2) Authorization for release of PHI Covering the period of healthcare (please check one)
   - o From ___/___/____ to ___/___/___
   - o All past, present, and future dates.
3) I hereby authorize the release of PHI as follows (please check one)
   - ☐ My complete health record (mental health, communicable diseases, HIV/AIDS, and treatment of alcohol and/or drug abuse)
   - ☐ Limited access to (check all that apply):
     - o Mental health records
     - o Communicable diseases (HIV/Aids)
     - o Alcohol/Drug abuse/treatment
     - o Medications (controlled and non- controlled)
4) This authorization will be valid for 1 year or 9 months after my death.
5) 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 authorization.
6) I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.
7) I understand that information used or disclosed to person(s) listed above will no longer be protected by federal or state law.

Patient Signature _____ Date of Birth___/___/___
Patient Name Printed _____ Today's Date ___/___/___

Patient Legal Representative Signature _____
Patient Legal Representative Printed Name _____ Today's date ___/___/___