

Authorization for Use or Disclosure of Protected Health Information

Patient Name: _____ Hospital/Physician/Provider: _____

Date(s) of Service: _____ Account Number: _____

I hereby authorize the hospital, physician or provider identified above to disclose and release my protected health information, as defined in the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), including billing, payment, insurance, and medical record information to:

Person/organization: _____

Address of person/organization: _____

Telephone number of person/organization: _____

Facsimile number of person/organization: _____

This authorization **does** ____ **does not** ____ include authorization to release psychotherapy notes. **(Note: If this authorization includes disclosure of psychotherapy notes, a second authorization must also be provided for release of any other protected health information)** This general authorization also includes specific authorization to release protected health information concerning **(initial all that apply)**:

_____ **The diagnosis or treatment of mental illness, or treatment for drug or alcohol abuse.**

_____ **Testing, diagnosis or treatment for HIV related or AIDS related illnesses and communicable disease related information.**

I understand that I may revoke or terminate this authorization in writing at any time, except to the extent the hospital, physician or provider has taken action in reliance upon my authorization.

This authorization is entered at my request as the patient, and for purpose of resolving **my third party liability claim** _____ or **my outstanding account** _____ (check one or both). This authorization is effective until my third party liability claim is resolved by settlement or final court decision, or my account is finally resolved, whichever occurs later if both apply.

I understand that information that is disclosed under this authorization may no longer be protected after it is disclosed and that it is not possible for the hospital, physician or provider that releases information under this authorization to ensure the privacy of any disclosed information after it is disclosed or that the information is used by the recipient identified above solely for the intended purpose.

Name of Patient or Personal Representative

Date

Signature

Relationship (if other than patient)

Notice: Any information released pursuant to this authorization is confidential and protected by state and federal law. Further disclosure is prohibited unless expressly authorized in writing by the person to whom it pertains or otherwise permitted by law. Federal law restricts any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.