# Abundant Health Family Practice

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## 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. Authorization**:
I authorize Abundant Health Family Practice to use and disclose the protected health information described below to:

Name: _____ Relationship_____

Name: _____ Relationship_____

**2. Effective Period**:
This authorization for release of information covers the period of healthcare from:

**A)** _____ to _____. **OR** **B)** ☐ All past, present, and future periods.

**3. Extent of Authorization:**

**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 shall be in force and effect until: _____ at which time this authorization expires.

**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.

****Patient agrees with authorizations list (1-8)**

**Name of Patient:** _____ **Patient Signature:** _____ **Date**: _____

**Parent/Legally Recognized Guardian**: _____ **Relationship to Patient**: _____