

# HIPPA/HIPAA AUTHORIZATION FORM

## Authorization to use and disclose protected health information

Patient Name			
Address			City
State	Zip	Phone Number	Birthday

I, the above-named patient, authorize the use or disclosure of my protected health information as described below:

### 1. AUTHORIZE PERSONS TO USE AND DISCLOSE PROTECTED INFORMATION

Facility / Provider Name "Provider"	Phone Number
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The "provider" is authorized to disclose the following protected health information to the following:

Person/Facility Name	Relation	Location	Phone Number

- If a person or facility listed above moves to a new location it **does not** invalidate this authorization form.

### 2. DESCRIPTION OF USES AND INFORMATION TO BE DISCLOSED

#### The health information that may be disclosed is:

Discharge Summary	Pathology report(s)	Behavioral Health Admitting Evaluation(s)
History & Physical	Radiology report(s)	Behavioral Health Discharge Summary
Consultations	Lab report(s)	Mental Health Therapy Records
Operative report(s)	Cardiology report(s)	Substance Use Disorder Treatment Records
Progress notes	Treatment Plan(s)	Emergency Records
Medical Records	Communicable diseases	Contact Info for (non-)emergency transportation services
Treatment Records	Appointment and scheduling records	Mental health records
		Discuss and assist with scheduling and potential treatment options
<b>Other:</b>	<b>Other:</b>	<b>Other:</b> All Records Including any that the above categories may not cover

All past, present, and future periods of health care information may be shared.

### 3. PURPOSE OF THE USE OR DISCLOSURE

The purpose of this use and/or disclosure is to assist \_\_\_\_\_ as needed.

### 4. VALIDITY OF THE AUTHORIZATION FORM

This Authorization Form is valid Starting: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ and remains in effect: **Until Further Notice**

### 5. ACKNOWLEDGMENT

I understand that the information used or disclosed under this Authorization Form may be subject to redisclosure by he person(s) or facility receiving it and would then no longer be protected by Federal privacy regulations.

I have the right to refuse to sign this Authorization Form. If signed, I have the right to revoke this authorization, in writing, at any time. I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.

Printed Name	Signature	Date
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