

Authorization for the Use and Disclosure of Individually Identifiable Health Information

**** YOU MAY REFUSE TO SIGN THIS AUTHORIZATION ****

Purpose: This form is used to request an individual's authorization for the use and disclosure of individually identifiable health information.

SECTION A: Individual granting authorization.

Individual's Name: _____

Address: _____

Telephone: _____ E-mail: _____

Individual's SSN: _____ - _____ - _____ Individual's Employer: _____

SECTION B: Descriptions

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that the information I authorize a person or entity to receive may be re-disclosed and no longer protected by federal privacy regulations.

1. Specific description of information that may be used / disclosed:

2. The information will be used / disclosed for the following purpose(s):

3. Persons / organizations authorized to use or disclose the information

4. Persons / organizations authorized to receive the information

5. Will the persons / organizations authorized to use / disclose the information receive compensation for doing so?
 Yes No

6. I understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment, payment for or coverage of services, or ability to obtain treatment, except as provided under numbers 7 and 8 on this form.

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7. If the purpose of this authorization is for {COMPANY NAME} to determine eligibility before enrollment, the requested use or disclosure is not for psychotherapy notes, and I refuse to sign this authorization, {COMPANY NAME} reserves the right to deny enrollment or eligibility for benefits
8. If the purpose of this authorization is to disclose health information to another party based on health care that is provided solely to obtain such information, and I refuse to sign this authorization, {COMPANY NAME} reserves the right to deny that health care.
9. I understand that I may inspect or copy the information used or disclosed.
10. I understand that I may revoke this authorization at any time by giving written notice of my revocation to {COMPANY NAME} at the address listed below, except to the extent that:
 - (a) action has been taken in reliance on this authorization; or
 - (b) if this authorization is obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.
- 11) I understand that revocation of this authorization will *not* affect any action you took in reliance on this authorization before you received my written notice of revocation.
- 12) This authorization expires on: _____

Please submit this form to:

{COMPANY NAME}
HIPAA OFFICIAL
{COMPANY ADDRESS}
{COMPANY CITY, STATE ZIP}

SIGNATURE—YOU MAY REFUSE TO SIGN THIS AUTHORIZATION.

I, _____, have had full opportunity to read and consider the contents of this authorization. I understand that, by signing this form, I am confirming my authorization that {COMPANY NAME} may use and/or disclose the protected health information described in this form for the purposes stated in this form.

Patient's Printed Name

Date

Patient's Signature

Date

If this authorization is signed by a personal representative on behalf of the individual, complete the following:

Patient Representative's Printed Name

Date

Patient Representative's Signature

Date

Relationship to Individual

YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION AFTER YOU SIGN IT.