

Instructions for Completing our HIPAA Privacy Authorization Form

If you would like someone other than yourself to have access to your medical records and information, and to allow us to release or disclose that information, you must authorize this. In this case we prefer it be in writing.

Since a **Durable Power of Attorney for Health Care** is only effective after you have lost your capacity to make or communicate decisions, the Power of Attorney does not authorize release of medical information while you remain competent. If you want someone other than yourself to have access to that information now, while you remain competent, you need to complete and sign our HIPAA Privacy Authorization Form, regardless of whether or not you also have a Durable Power of Attorney for Health Care in place.

This is a **General Authorization** form and should be filled out by the patient or their personal representative requesting the release, rather than the entity or person receiving or releasing the information. However, if you need help filling out this form we are happy to provide assistance.

In Section 1 insert the **name** of health care provider (hospital, physician, practice, etc.) you are authorizing to release your information (most often this will be our practice name), and the name of person or entity authorized to receive the information. You may use a single form to designate multiple persons or entities who are authorized to receive your information.

In Section 2 indicate **time period** of information covered by the authorization, and **what information** is allowed to be released.

In Section 4 indicate how long the authorization is to remain **effective**, for example until a certain date or until your death. You have the power to revoke, the authorization in writing at any time by notifying the entity or person you have authorized to release information.

The form needs to be **signed by the patient** or by the personal representative of the patient, such as a parent if the patient is a minor.

This General Authorization form may not be used for:

- Authorizations to use PHI for Marketing
- Specific authorizations for *use* of PHI other than allowed by law
- Conditional authorizations relating to research or insurance benefits

Patient initials _____

**Wholesome Health
HIPAA Privacy Authorization Form**

Authorization for Disclosure or Release of Protected Health Information
(Required by the Health Insurance Portability and Accountability Act – 45 CFR Parts 160 and 164)

1. I hereby authorize _____
to disclose the protected health information described below to _____
_____.

2. I hereby authorize release of information covering the period of health care from (check appropriate box):
 _____ to _____ **OR** all past, present and future periods

Information to be released (check appropriate box):

2a. I hereby **authorize the release of my complete health record** (including records relating to mental health care, communicable diseases, HIV or AIDS, and treatment of alcohol/drug abuse).

OR

2b. I hereby **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): _____

3. This protected health information may be used by the person(s) or entities I authorize to receive it, for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

4. This authorization shall be in force and effect until this date or event: _____,
at which time it expires.

5. I understand that I have the right to revoke this authorization in writing at any time, but that some actions already taken based on my original authorization may not be reversible.

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 under this authorization may be further disclosed by certain recipients, and in some cases may no longer be protected by federal or state law.

Signature of Patient or Personal Representative

Date

Print Name of Patient or Personal Representative

Relationship to Patient