

HIPAA privacy regulations stipulate that health care providers may not use or disclose a patient's health information without his or her authorization, except as described in the Notice of Privacy Practices. That document clarifies the conditions under which a patient's information may be released without his or her authorization, and when an express authorization is required by the patient.

Under certain circumstances, it may become necessary for this office to release a patient's health information to an individual or entity outside of this office. In accordance with the Notice of Privacy Practices, this office, via this authorization form, requests that the patient indicated below authorize the release of his/her health information.

I, the undersigned, understand that I have the right to:

- refuse to sign this authorization
- receive a copy of this authorization
- restrict what is disclosed by this authorization
- inspect or request an amendment of the health information to be disclosed
- revoke this authorization, by written notice
- know about any compensation the practitioner/facility will receive resulting from the release of my health information

I recognize that once disclosed my health information is no longer under the control of this practitioner/facility. While I understand that the practitioner/facility will make a good faith effort to release my information only to trusted recipients, my health information may be re-disclosed by subsequent parties, and thus may no longer be protected by this office's privacy practices.

I understand that whether or not I sign this document will not effect my treatment at this practice, the payments I incur here, or my eligibility for benefits of any sort. If I do experience any such negative repercussions, I have the right to file a complaint with the Office of Civil Rights of the U.S. Department of Health and Human Services. I can find the Office for Civil Rights for my state at: <http://www.hhs.gov/ocr/regmail.html>.

Patient Name: \_\_\_\_\_

Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Health information to be disclosed: \_\_\_\_\_

Individual(s), entities or business associates to receive this health information:

Specific purpose of this disclosure:

Effective dates of this authorization: \_\_\_\_/\_\_\_\_/\_\_\_\_ through \_\_\_\_/\_\_\_\_/\_\_\_\_  
(The authorization will expire at the end of this period)

I hereby authorize this office to disclose my health information as described in this document.

Signature of Patient (or authorized representative)

Date

Signature of Practitioner or Facility Representative

Date



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