HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Date: _____, 20____

I. **THE PATIENT**. This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

Patient's Name: _____
Date of Birth: _____, 20____
Social Security Number: _____-____-_____

II. **AUTHORIZATION**. I authorize _____ ("Authorized Party") to use or disclose the following: (check one)

☐ - All of my medical-related information.
☐ - My medical information ONLY related to: _____.
☐ - My medical-related information from _____, 20____ to _____, 20____.
☐ - Other: _____.

Hereinafter known as the "Medical Records."

III. **DISCLOSURE**. The Authorized Party has my authorization to disclose Medical Records to: (check one)

☐ - Any party that is approved by the Authorized Party.
☐ - ONLY the following party:
Name: _____
Address: _____
Phone: (____) ____-_____ Fax: (____) ____-_____
E-Mail: _____

IV. **PURPOSE**. The reason for this authorization is: (check one)

☐ - **General Purpose**. At my request (general).

☐ - **To Receive Payment**. To allow the Authorized Party to communicate with me for marketing purposes when they receive payment from a third party.

☐ - **To Sell Medical Records**. To allow the Authorized Party to sell my Medical Records. I understand that the Authorized Party will receive compensation for the disclosure of my Medical Records and will stop any future sales if I revoke this authorization.

☐ - **Other**: _____.