

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:** _____