



# HIPAA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information (Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

## 1. Authorization

I authorize \_\_\_\_\_ (healthcare provider) to use and disclose the protected health information described below to the Center for Vascular Intervention and Dr. Douglas Redd or Belinda Marcus.

## 2. Effective Period

This authorization for release of information covers the period of healthcare from:

- a.  \_\_\_\_\_ to \_\_\_\_\_ **\*\*OR\*\*** b.  all past, present, and future periods.

## 3. Extent of Authorization

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

**\*\*OR\*\***

- b.  I 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): \_\_\_\_\_

4. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

5. This authorization shall be in force and effect until \_\_\_\_\_ (date or event), at which time this authorization expires.

6. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

7. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

8. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

\_\_\_\_\_  
Signature of patient or personal representative

\_\_\_\_\_  
Patient Birthdate

\_\_\_\_\_  
Printed name of patient or personal representative (and relationship to patient)

\_\_\_\_\_  
Date