Model Authorization Form under HIPAA*

This form should be used when release of a patient's protected health information is being made to anyone for a purpose other than treatment, payment or health care operations. The form should be adapted to meet the needs of a particular situation and a particular physician practice. Releases in which the form will be needed are discussed in the KMA HIPAA material regarding Authorizations. The information in brackets that is underlined should be filled in by the practice. Other information in brackets is designed to assist the patient in filling out the form.

I, _____, hereby authorize _____ to use and/or disclose my
Name of Patient Name of Physician/Practice
protected health information described below to _____.
Name of Person or Entity to receive the information

My protected health information will be used or disclosed upon request for the following purposes [please name and explain each purpose]:

This authorization for use and/or disclosure applies to the information described below [mark those that apply]:

- ❑ Any and all records in the possession of _____ including mental health, HIV, and/or substance abuse records. [Cross out any item you do not authorize to be released]
  Name of Physician/Practice
- ❑ Records regarding treatment for the following condition or injury _____ on or about _____.
- ❑ Records covering the period of time _____ to _____.
- ❑ Other [please specify - include dates] _____.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to

_____.
Name and Address of Contact Person at the Practice

I also understand that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my protected health information have acted in reliance upon this authorization.

I understand that I do not have to sign this authorization and that _____ may not
Name of Physician/Practice
condition treatment or payment on whether I sign this authorization.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by federal laws and regulations regarding the privacy of my protected health information.

This authorization expires on [please list a specific date or event] _____.

I certify that I have received a copy of this authorization.

_____ _____
Signature of Patient or Personal Representative Date

_____
Name of Patient or Personal Representative

_____
Description of Personal Representative's Authority

*The source of this document is the Kentucky Medical Association.