

HIPA PRIVACY AUTHORIZATION FORM

Authorization for Use or Disclosure of Protected Health Information

Required by applicable state law and the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164.

I. AUTHORIZATION

I authorize _____ (healthcare provider), whose address is _____, city: _____, state: _____, zip: _____, to use and disclose the protected health information, described below, to James H. Lockwood Esq. (individual seeking the information), whose address is 26418 Olympic Club drive, South Bend, IN. 46628.

II. EFFECTIVE PERIOD

This authorization for release of information covers the period of healthcare from _____ to _____.

III. EXTENT OF AUTHORIZATION

A. {Initial ONLY one}

_____ 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

_____ I authorize the release of my complete health record WITH THE EXCEPTION OF the following information: records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).

This authorization shall be in force and effect until January 1, 2021 at which time this authorization expires.

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.

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

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.

Date: _____

Signature of Patient or Personal Representative

Print patient's address:

Print patient's date of birth:

Patient's social security number:

_____ **Witness** _____

Printed Name of Witness: