HIPAA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information
(Required by the Health Insurance Portability and Accountability Act- 45 CFR Parts 160 and 164)

1. I hereby authorize___Hills E.N.T. Institute________ to use and/or disclose the protected health information described below to:

Name: ____________________________________ Relationship: _________________________________

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Health information to be disclosed upon the request of the person named above ***(Check either A or B)***

- ☐ A. **Disclose** my complete health record (including but not limited to diagnoses, lab tests, prognosis, treatment, and billing for all conditions) **OR**
- ☐ B. **Disclose** my health record, as above, **BUT do NOT disclose** the following (check as appropriate):
  - o Mental Health records
  - o Communicable diseases (including HIV and AIDS)
  - o Alochol/drug abuse treatment
  - o Other (please specify)

    ____

    ____

2. Authorization for Release of Information. Covering the period of health care from the following dates
   - ☐ All past, present, and future periods, OR
   - ☐ Date or event: ____
3. 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.
4. 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.
5. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.
6. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer by protected by federal or state law.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request.

____ ___________________

Signature of Patient or Personal representative Date

____ ___________________

Print Name of Patient or Personal Relationship to patient

This Notice of Privacy Practices applies to the following organizations: HILLS ENT INSTITUTE

Privacy Officer: Dr. David Schleimer, DO

Email: David.schleimer@hills-ent.com Phone: 248.268.0178

Last Revised: May 8, 2023