Hümi | ENT & Allergy Associates

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

Patient Name	Date of Birth	Social Security No.
Patient Address		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form. In accordance with applicable state and federal law, including the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to ALCOHOL OR SUBSTANCE USE TREATMENT, MENTAL HEALTH TREATMENT (except psychotherapy notes), HIV/AIDS-RELATED INFORMATION, AND OTHER SENSITIVE HEALTH INFORMATION only if I specifically authorize the release of such information as indicated elsewhere on this form, where required by applicable law.

2. If I am authorizing the release of HIV/AIDS-related information, alcohol or substance use treatment information, mental health treatment information, or other specially protected health information, the recipient may be prohibited from redisclosing such information except as permitted or required by applicable federal or state law. I understand that certain types of health information may receive additional protections under federal and state law.

3. I have the right to revoke this authorization at any time by providing written notice to the health care provider, facility, or organization identified on this form. I understand that revocation will not apply to actions already taken in reliance on this authorization.

4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure, except as permitted by law.

5. Information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state privacy laws, unless otherwise prohibited by applicable law.

6. THIS AUTHORIZATION DOES NOT AUTHORIZE ANY PERSON OR ENTITY TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE INDIVIDUAL(S), ATTORNEY(S), ORGANIZATION(S), OR GOVERNMENT AGENCY(IES) SPECIFICALLY IDENTIFIED IN THIS AUTHORIZATION.

7. Name and address of health provider or entity to release this information:

8. Name and address of person(s) or category of person to whom this information will be sent:

9(a). Specific information to be released:

- ❑ Medical Record from *(insert date)* _____ to *(insert date)* _____
- ❑ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
- ❑ Other: _____

_____

Include: (Indicate by Initialing)

_____ **Alcohol/Drug Treatment**

_____ **Mental Health Information**

_____ **HIV-Related Information**

Authorization to Discuss Health Information

(b) By initialing here _____ I authorize _____

Initials *Name of individual health care provider*

to discuss my health information with my attorney, or a governmental agency, listed here:

_____

(Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information:
- ❑ At request of individual
- ❑ Other: _____

11. Date or event on which this authorization will expire:

12. If not the patient, name of person signing form:

13. Authority to sign on behalf of patient:

All items on this form have been completed, and my questions about this form have been answered. In addition, I have been provided with a copy of the form.

_____ Date: _____

Signature of patient or representative authorized by law.