## 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 \_\_\_\_\_ Dr. Libby Black (healthcare provider) to use and disclose the protected health information described below to Crisis Intervention, ie local police \_\_\_\_\_ (individual seeking the information). Adult Protective Services (APS), Emergency Medical Services (EMS) \*\*2. Effective Period\*\* This authorization for release of information covers the period of healthcare from: \*\*OR\*\* b.  $\square$  all past, present, and future periods. \*\*3. Extent of Authorization\*\* a.  $\Box$  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) XAlcohol/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. (3-month period)
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.
X
Signature of patient or personal representative
Printed name of patient or personal representative and his or her relationship to patient
Date (Todays Date)