

HIPAA Release to Authorized Persons - Regarding Patient: _____

(1) This release authority applies to any information governed by the Health Insurance Portability and Accountability Act of 1996 (a/k/a HIPAA), 42 USC 132d and 45 CFR 160-164. Specifically, this release authority complies with the valid authorization requirements of 45 CFR 164.508(c).

(2) Pursuant to HIPAA, I authorize and direct any physician, healthcare professional, dentist, health plan, hospital, clinic, laboratory, pharmacy, or other covered health care provider, any insurance company, and the Medical Information Bureau, Inc., or other health care clearinghouse that has provided treatment or services to me or that has paid for or is seeking payment from me for such services, to **give, disclose, and release**, without restriction, all of my individually identifiable health information and medical records regarding any past, present, or future medical or mental health condition, to include all information relating the diagnosis and treatment of sexually transmitted diseases, mental illness, and drug or alcohol abuse separately to the following **person or persons:** (herein "Authorized Person(s)")

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(3) This authorization specifically applies to all health care providers and any records that may be requested.

(4) The purpose of the use and disclosure shall include assistance by my Authorized Person(s) in monitoring my health care and sharing my health care status with family and friends for my benefit.

(5) I understand that, with certain exceptions, I have the right to revoke this Authorization at any time. If I want to revoke this Authorization, as well as the exceptions to my right to revoke, that revocation will be performed in accordance with applicable federal law and any applicable policy of my health care provider.

(6) I understand that, once information is disclosed pursuant to this Authorization, it is possible that it will no longer be protected by applicable federal medical privacy law and could be re-disclosed by the person or agency that receives it, however, I do not authorize such secondary disclosure.

(7) The authority given to said Authorized Person(s) shall supercede any prior agreement that I may have made with my health care providers to restrict access to or disclosure of my individually identifiable health information. The authority given has no expiration date and shall expire only in the event that I revoke the authority in writing and deliver it to my health care provider.

(8) Reproductions of this Release shall be considered as effective and valid as the original.

I have read and understand the information in this authorization form.

Date: _____

Signature: _____

Witnesses:
