**HIPAA AUTHORIZATION**

**STATEMENT OF INTENT**

It is my understanding that Congress passed a law entitled the Health Insurance Portability and Accountability Act (“HIPAA”) that limits disclosure of my protected health information. This authorization is being signed because it is crucial that my health care providers readily give all of my protected health information to the persons designated in this authorization for the purpose of having them fully informed and able to assist me as to all matters related to my health, medical condition, and/or treatment.

 Therefore, pursuant to 45 CFR 164.502(a)(1)(iv), a covered entity (being a health care provider as defined by HIPAA) is permitted to disclose protected health information pursuant to and in compliance with this valid authorization under 45 CFR 164.508.

**AUTHORIZATION**

 I, **NAME**, an individual, hereby request and authorize all covered entities as defined in HIPAA, including but not limited to a doctor, (including but not limited to a physician, podiatrist, chiropractor, or osteopath) psychiatrist, psychologist, dentist, therapist, nurse, hospitals, clinics, pharmacy, laboratory, ambulance service, assisted living facility, residential care facility, bed and board facility, nursing home, medical insurance company or any other health care provider or affiliate, to disclose the following information:

All protected health information (including but not limited to records relating to mental health, communicable diseases, HIV or AIDS, and treatment of alcohol or drug use), all information, reports and/or records concerning my medical history, condition, diagnosis, testing, prognosis, treatment, billing information and identity of health care providers, whether past, present or future and any other information which is any way related to my health. Additionally, this disclosure shall include the ability to ask questions and discuss this protected health information with the person or entity who has possession of the protected health information even if I am fully competent to ask questions and discuss this matter at the time. It is my intention to give a full authorization to ANY protected health information to the persons named in this authorization.

to the following authorized persons:

 Name:

 Address:

 Telephone:

Name:

Address:

Telephone:

Name:

 Address:

 Telephone:

**TERMINATION AND REVOCATION**

 This authorization shall terminate on the first to occur of: (1) two years following my death or (2) upon my written revocation actually received by the covered entity. I understand I have the right to revoke this authorization, in writing, at any time. Proof of receipt of my written revocation may be by certified mail, registered mail, facsimile, or any other receipt evidencing actual receipt by the covered entity. This revocation shall be effective upon the actual receipt of the notice by the covered entity except to the extent that the covered entity has taken action in reliance on it. This authorization is not affected by my subsequent disability of incapacity.

**RE-DISCLOSURE**

 By signing this Authorization, I acknowledge that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the person or persons whose name(s) is/are written above, and the information once disclosed may no longer be protected by the rules created in HIPAA. No covered entity shall require my authorized persons to indemnify the covered entity or agree to perform any act in order for the covered entity to comply with this authorization.

**INSTRUCTIONS TO MY AUTHORIZED PERSONS**

 My authorized persons shall have the right to bring a legal action in any applicable form against any covered entity that refuses to recognize and accept this authorization for the purposes I have expressed. Additionally, my authorized persons are authorized to sign any documents that the authorized persons deem appropriate to obtain the protected health information.

**VALID DOCUMENT**

 A copy, photocopy, or facsimile of this original authorization shall be accepted as though it were an original document.

I understand this authorization is voluntary and that the covered entity to whom this authorization is directed may not condition treatment, payment, enrollment or eligibility for benefits on whether or not I sign this authorization.

Signed on the \_\_\_\_\_\_\_\_ day of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, 2018.

 Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Printed Name: Name

 Date of Birth: Date