HIPAA Authorization for Use & Disclosure of My Protected Health Information

Name of Health Care Provider/Facility: ______________________________

Patient name: ______________________________ **Date of birth:** ____________

SSN #:______________________ Previous name: ______________________

I. My Authorization

You may use & disclose the following protected health care information (check all that apply):

☒ Any health information maintained by the above named health care provider/facility:

Part I: ☒ **I understand that if the information in my health record includes information relating to behavioral or mental health services (psychological, psychiatric or other mental conditions, including psychotherapy notes), treatment for alcohol and/ or drug diagnosis/abuse, sexually transmitted diseases, Hepatitis B or C testing, sickle cell anemia, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), I agree to its release and authorize disclosure.**

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Part II:

☐ **Any report (not contained in Part I)**	☐ **Any physician record / report**	☐ **Any non-physician record / rpt**
☐ **Admission / Consultation reports**	☐ **Any Radiology / Lab reports**	☐ **NARSIS Patient Care reports**
☐ **Emergency Room records / reports**	☐ **Any diagnostic test / records**	☐ **Patient / Personal Info. / History**
☐ **History & Physical / hospital reports**	☐ **Nurse Rec. / Notes (ER/other)**	☐ **Nurse Data / Social / Question.**
☐ **Discharge Summary / records**	☐ **Operative / Procedure reports**	☐ **Progress / Flow sheet / Intake**
☐ **Office notes / correspondence**	☐ **PT/OT records / reports**	☐ **Medical Bills / Prescription bills**

☒ **Note: This release does authorize and permit oral communications.**

☐ My health information relating to the following treatment or condition: ______________________

☐ My health information for the date(s): ______________________

☐ Other: ______________________

You may disclose this health information to:

Name (or title) and organization: **Golden Halo Foundation**

Reason(s) or purpose(s) for this authorization (check all that apply):

Personal ☐ Other (specify) ____________ ☐

This authorization expires: ☒ on (date) ____________ (180 days)
☐ when the following event occurs ______________________

II. My Rights

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment). However, I do have to sign an authorization form:

- To take part in a research study. or
- To receive health care when the purpose is to create health information for a third party.

I may revoke this authorization in writing. If I do, it will not affect any actions already taken by the above named health care provider/facility based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. Two ways to revoke this authorization are:

- Fill out a revocation form. The form is available from the office, or
- Write a letter to the office.

I understand and acknowledge that once the health care provider/facility discloses my Protected Health Information (PHI), Golden Halo Foundation reserves the right to re-disclose any information received. Any photo static or facsimile copy of this authorization shall be as effective as any original signed by me until the subject matter of this litigation is finalized. HIPAA Privacy laws and/or regulations (45 CFR, Title II, Section 164, et. seq.) may no longer protect it.

______________________ Patient or legally authorized individual signature

______________________ Date

______________________ Printed Name if signed on behalf of the patient

______________________ Relationship (parent, legal guardian, personal representative, etc.)