HIPAA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information

Required by the Health Insurance Portability and Accountability Act (HIPAA) 45C.F.R. Parts 160 and 164

1. Authorization
   I authorize Melissa Kinder, MD to use and disclose the protected health information described below to:

   _____ _____
   individual seeking the information (please print) relationship to patient

2. Effective Period
   This authorization for release of information covers the period of healthcare from
   ☐ _____ to _____ OR
   ☐ All past, present and future periods.

3. Extent of Authorization
   ☐ 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)

   ☐ 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)
   - ☐ Alcohol/drug abuse treatment
   - ☐ Other (please specify) _____

The medical information may be used by the person I authorize to receive this information for medical treatment or consultations, bill or claims payment or other purposes as I may direct.

This authorization shall be in force and effect until I provide written notice revoking permission.

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 that 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.

I understand that my treatment, payment, enrolment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

I understand that information used or disclosed pursuant to this authorization bay be disclosed by the recipient and may no longer be protected by federal or state law.

_____ _____
Patient Name (please print) Date of Birth

_____ _____
Signature of patient or personal representative Date