Instructions for Completing
HIPAA Privacy Authorization Form

If you would like some person other than yourself to have access to your medical records and information, and allow health care providers to release such information to that person, you must authorize the release of the information in writing. Since a Durable Power of Attorney for Health Care is only effective after you have lost your capacity to make or communicate decisions, the Power of Attorney does not authorize release of medical information to the person named while you remain competent. If you want some person other than yourself to have access to that information now, while you remain competent, you need to complete and sign a HIPAA Privacy Authorization Form, regardless of whether or not you also have a Durable Power of Attorney for Health Care in place.

In **Section 1** you need to insert the name of the health care provider (hospital, physician, etc.) who is authorized to release the information, and the name of the person who is authorized to receive the information.

In **Section 2** you first need to indicate what **time period** is covered by the authorization, and then what **type** of information is allowed to be released.

In **Section 4** you need to indicate **how long** the authorization is to remain effective, for example until a certain date or until your death. You retain the power to **revoke** the authorization at any earlier time.

The form needs to be **signed** by the patient or by the personal representative of the patient, such as a parent if the patient is a minor. You must complete a separate form for each health care provider you want to authorize to release information. We suggest you photocopy the form for multiple use.

HIPAA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information
(Required by the Health Insurance Portability and Accountability Act – 45 CFR Parts 160 and 164)

1. I hereby authorize Northwest Pain Care, Inc. to use and/or disclose the protected health information described below to _____.
[Name of Health Care Provider] [Name of Individual]

2. Authorization for Release of Information. Covering the period of health care from

☐ _____ to _____ **OR** ☐ all past, present and future periods:

a. ☐ I hereby **authorize the release of my complete health record** (including records relating to mental health care, communicable diseases, HIV or AIDS, and treatment of alcohol/drug abuse).

OR

b. ☐ I hereby **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): _____

3. 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.

4. This authorization shall be in force and effect until _____, at which time this authorization expires.
[Date or Event]

5. 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.

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

7. 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.

_____ _____
Signature of Patient or Personal Representative Date

_____ _____
Print Name of Patient or Personal Representative Relationship to Patient