HIPAA Authorization Form (Plan)

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Complete entire form.

I hereby authorize the use or disclosure of my protected health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

Name: __________________________________________

ID Number: _______________________________________

This authorization will expire on __/__/__ (DD/MM/YYYY) or ____________________________________________ (event, such as end of research study).

Persons/organizations providing the information: (Name or Identifying Information)
______________________________________________________________________________________________
______________________________________________________________________________________________
______________________________________________________________________________________________
______________________________________________________________________________________________

Person/organizations receiving the information: (Name or Identifying Information)
______________________________________________________________________________________________
______________________________________________________________________________________________
______________________________________________________________________________________________
______________________________________________________________________________________________

Specific description of information (including date(s)): ________________________________________________
______________________________________________________________________________________________
______________________________________________________________________________________________
______________________________________________________________________________________________

What is the purpose of the use or disclosure? (State purpose or note it is at the request of the employee)
______________________________________________________________________________________________

The employee or employee’s representative must read and initial the following statements:

1. I understand that I may revoke this authorization at any time by notifying the ____________ Privacy Officer [agency name and address] in writing. However, if I do revoke this authorization it won’t have any effect on any actions the County has taken before it received the revocation. Initials: ______

2. I understand that health care and payment for my health care will not be denied if I do not sign this form. Initials: ______

3. I understand I am not required to sign this form to receive my health care benefits (enrollment, treatment or payment, etc.) Initials: ______

4. I understand the information that is used or disclosed pursuant to this authorization may be re-disclosed by the receiving entity. I have the right to seek assurance from the above name and persons/organizations authorized to receive this information that they will not re-disclose the information to any party without further authorization. Initials: ______

5. I understand that I will get a copy of this form after I sign it. Initials: ______

Required Notice
I understand that the information disclosed under this authorization may be re-disclosed by the recipient if not prohibited under Federal or State law.

______________________________________________________
Signature of individual or individual’s representative
(Form MUST be completed before signing)

__________________________
Date

Printed name of individual’s representative: __________________________________________________________

Relationship to the individual: ________________________________________________________________

*YOU MAY REFUSE TO SIGN THIS AUTHORIZATION*