HIPAA Authorization Form (Standard)

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 individual)
____

____

The individual or the individual'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 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 redisclosed by the recipient if not prohibited under Federal or State law.

____ ___________________________
Signature of individual or individual's representative Date
(*Form MUST be completed before signing)*

Printed name of individual's representative: ____

Relationship to the individual: ____

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION