Disclosure of Protected Health Information

HIPAA AUTHORIZATION

This document contains authorization as required under the final privacy rules issued by HHS pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This form reflects only the federal requirements under HIPAA and not any additional requirements imposed by states. Unless otherwise noted, all items in this form must be completed. Please note that this model form does not reflect Federal Substance Abuse Confidentiality Requirements. Those requirements are explained at the end of the form.

I authorize the use/disclosure of health information about me as described below.

1. Person(s) or class of persons authorized to use/disclose the information:

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2. Person(s) or class of persons authorized to receive the information:

3. Description of information that may be used/disclosed:

All Information____

4. The information will be used/disclosed for the following purposes: (Note: this item is not required if the disclosure is requested by the patient.)

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5. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and no longer protected by these regulations.

6. [*If applicable*] I understand that the person I am authorizing to use/disclose the information will receive compensation for doing so. (Note: this item is not required if the disclosure is requested by the patient.)

7. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or copy any information used/disclosed under this authorization. (Note: this item is not required if the disclosure is requested by the patient.)

8. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance on this authorization. This authorization expires _____________ [*insert applicable date or event*].

____ ____________________

Signature of Patient or Representative Date

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Patient's Name

____ ____________________

Name of Personal Representative (if applicable) Relationship to Patient

(A copy of this signed form will be provided to the patient)

Additional Federal Substance Abuse Confidentiality Requirements

Item # 4 -- Under the Federal Substance Abuse Confidentiality Requirements, an authorization must include the purpose of the disclosure of substance abuse information even if the patient requests the disclosure.

Item #5 – Under HIPAA, this item #5 which warns patients that information disclosed may be subject to redisclosure, must be included in the authorization. However, under the Federal Substance Abuse Confidentiality Requirements, identifiable substance abuse information may not be redisclosed unless permitted by (a) the Federal Substance Abuse Confidentiality regulations or (b) the patient's authorization. Therefore, if the authorization is for the disclosure of substance abuse information, a hospital may want to add the following statement after item #5: "However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements."