HIPAA RELEASE AUTHORITY: A SPOUSE, CHILD, RELATIVE, FRIEND, ETC.

I intend for the person named below to be treated as I would be with respect to my rights regarding the use and disclosure of my individually identifiable health information or other medical records. This release authority applies to any information governed by (HIPAA), 42 USC 132od and 45 CFR 160-164. I authorize:

a. Any physician, health care professional, dentist, health plan, hospital, clinic, laboratory, pharmacy or other covered health care provider, any insurance company and the Medical Information Bureau, Inc. or other health care clearing house that has provided me treatment or services, or that has paid for or is seeking payment from me of such services.
b. To give, disclose and release to the person named below, without restriction: All of my individually identifiable health information and medical records regarding any past, present or future medical or mental health condition, to include all information relating to the diagnosis and treatment of HIV/AIDS, sexually transmitted diseases, mental illness and drug or alcohol abuse.

I HEREBY AUTHORIZE: name of authorized person i.e.: (spouse, child, relative, friend, etc.):

_____

Address: _____

Telephone: _____

Relationship:_____

TO HAVE ACCESS TO MY MEDICAL RECORDS AS INDICATED ABOVE.

The authority given shall supersede any prior agreement that I may have made with my health care providers to restrict access or disclosure of my individually identifiable health information. The authority given has no expiration date and shall expire only in the event that I revoke the authority, in writing, and deliver it to my health care provider.

Patient signature: _____ Date: _____

Patient (Print Name) _____

Patients Date of Birth:_____