HIPAA Privacy Authorization Form

\*\*Authorization for Use or Disclosure of Protected Health Information

(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R Parts 160 and 164)\*\*

\*\*1. Authorization

I authorize \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(healthcare provider) to use and disclose the protected health information described below to Elesha Snyder of the Breast Wishes Foundation.

\*\*2. Effective Period

This authorization for release of information covers the period of healthcare from

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_to present (time patient has been treated for breast cancer)

\*\*3. Extent of Authorization

I authorize the release of my health record ONLY as it pertains to breast cancer diagnosis

4. 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.

5. This authorization shall be in force and effect until \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(one month from today’s date) at which time this authorization expires.

6. 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.

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.

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Signature of patient or personal representative

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Printed name of patient or personal representative and his or her relationship to patient