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OBSTETRICS • GYNECOLOGY • INFERTILITY

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HIPAA AUTHORIZATION FORM

INDIVIDUAL'S NAME (please print): _____ **DATE OF BIRTH:** _____

INDIVIDUAL'S ADDRESS _____

I hereby authorize use or disclosure of protected health information about me as described below.

1. The following specific person/class of person/facility is authorized to *use or disclose information* about me:

2. The following person (or class of persons) *may receive disclosure* of protected health information about me:
His/her/its name and address:

3. The specific information that should be disclosed is (please give dates of service if possible):

UNLESS YOU SIGN HERE, NO INFORMATION ABOUT ALCOHOL/SUBSTANCE ABUSE, HIV/AIDS, OR MENTAL HEALTH WILL BE DISCLOSED: YES, DISCLOSE THIS INFORMATION _____

NO, DO NOT DISCLOSE THIS INFORMATION _____

4. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations.
5. I may revoke this authorization by notifying _____ in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.
6. This authorization expires on _____, 200____, OR upon occurrence of the following event that relates to me or to the purpose of the intended use or disclosure of information about me: _____.

FEES FOR COPIES: Federal and state laws permit a fee to be charged for the copying of patient records. This facility has contracted with Smart Document Solutions to make copies. You may be required to pre-pay for the copies; if not, then your copies will be mailed along with an invoice.

THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING – note that signature is required in two places.

Signature of Individual
(The person about whom the information relates)

Date of Individual's Signature

Date of Birth or Social Security Number

OR, if applicable –

Signature of Guardian or
Personal Representative of Patient's Estate

Date of Guardian's/Personal
Representative's Signature

Description of Authority to Act for
the Individual

A copy of this completed, signed and dated form must be given to the Individual or other signator.