HIPAA PRIVACY AUTHORIZATION FORM

This is an authorization to release, use, or disclose protected health information.

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

To authorize you must fill in all required fields, please write legibly.

I authorize ***Relaxed Clarity and MedEval Clinics*** *(Clinic or Healthcare Provider)*
to release, use or disclose the protected information described below to:(Person or entity seeking the information)
Name/Facility: _____ *Address:* _____
Phone: _____ *Fax:* _____ *Email:* _____

(Note: All records must be faxed to the recipient or the patient may pick up records from the clinic with valid ID.)

Reason for release: _____

This authorization for release of information will be effective for all past, present and future periods.

I authorize the release of any and all records on file including my complete health record (this may include records of mental health, communicable disease, HIV or AIDS, and the treatment of substance abuse).

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.

This authorization shall remain in effect for 180 days after my signature date or until a date specified. Any specified date will allow this form to expire after the date listed. (Please only list a date if you wish for this form to expire earlier than 180 days)
Date or event: _____

I understand that I have the right to revoke this authorization, in writing, at any time. I understand the 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.

I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization for release.

I understand that information used or disclosed pursuant to this authorization for release may be disclosed by the recipient and may no longer be protected by federal or state law.

Signature of Patient or Personal Representative: _____

Printed name of Patient: _____ *DOB:* _____ *Last four of SSN:* _____

Date Signed: _____ *(Authorization expires 180 days from this date unless otherwise specified)*

Patient Address: _____ *State:* _____ *City:* _____ *Zip:* _____