HIPAA Authorization Release Form

Notice of Privacy Practices Acknowledgement

________ (Patient initials) I acknowledge that I have received HHM Health Notice of Privacy Practices, which describes the ways in which the practice may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures, I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the HHM Health Notice of Privacy Practices.

STATEMENT OF INTENT

It is my understanding that Congress passed a law entitled the Health Insurance Portability and Accountability Act ("HIPAA") that limits disclosure of my protected medical information. This authorization is being signed because it is crucial that my medical providers readily give my protected medical information to the persons designated in this authorization in order to allow me the advantage of being able to discuss and obtain advice from my family and/or friends.

Therefore, pursuant to 45 CFR 164.501(a)(1)(iv) a covered entity (being a health care provider as defined by HIPAA) is permitted to disclose protected health information pursuant to and in compliance with this valid authorization under 45 CFR Sec. 164.508.

AUTHORIZATION

I, ____, an individual, hereby authorize all covered entities as defined in HIPAA, including but not limited to a doctor, (including but not limited to a physician, podiatrist, chiropractor, or osteopath,) psychiatrist, psychologist, dentist, therapist, nurse, hospitals, clinics, pharmacy, laboratory, ambulance service, assisted living facility, residential care facility, bed and board facility, nursing home, medical insurance company or any other health care provider or affiliate, to disclose the following information:

> All health care information, reports and/or records concerning my medical history, condition, diagnosis, testing, prognosis, treatment, billing information and identity of health care providers, whether past, present or future and any other information which is in any way related to my healthcare. Additionally, this disclosure shall include the ability to ask questions and discuss this protected medical information with the person or entity who has possession of the protected medical information even if I am fully competent to ask questions and discuss this matter at the time. It is my intention to give a full authorization to ANY protected medical information to the persons named in this authorization.

Disclosures to Friends and/or Family Members

I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below:

1. Name: ________________________________Relationship: ___________________ Phone No.: __________________
2. Name: ________________________________Relationship: ___________________ Phone No.: __________________
3. Name: ________________________________Relationship: ___________________ Phone No.: __________________

□ **Information is not to be released to anyone.**

Complete the following by indicating those items that you want you want disclosed. The signature of a minor patient is required for the release of some of these items. If all health information is to be released, then check only the first box.

☐ **All health information**

☐ History/Physical Exam ☐ Past/Present Medications ☐Lab Results ☐Physician's orders

☐Patient Allergies ☐ Operation Reports ☐ Consultation Reports

☐ Progress Notes ☐ Discharge Summary ☐ Diagnostic Test Reports

☐ EKG/Cardiology Reports ☐ Pathology Reports ☐ Billing Information ☐ Radiology Reports & Images

☐ Mental Health Records (excluding psychotherapy notes) ☐ Genetic Information (including Genetic Test Results)

☐ Drug, Alcohol, or Substance Abuse Records ☐ HIV/AIDS Test Results/Treatment

☐ Other____

DELEGATION OF CONSENT – Please complete if patient is under 18 years of Age

I, ____, ________________________________ as parent/legal guardian

PRINTED NAME RELATIONSHIP TO CHILD

give my permission to the following persons listed below to bring the above named child to HHM Health for treatment and to consent to all immunizations, injections, or other medical therapies and procedures as they seem appropriate.

1. Name: ________________________________DOB: ____________________Relationship to Child: ________________
2. Name: ________________________________DOB: ____________________Relationship to Child: ________________
3. Name: ________________________________DOB: ____________________Relationship to Child: ________________

Signature: ____Date: _______________________

Signature of Individual or Individual's Legally Authorized Representative

HHM Administrated 1.1.07, Revised 2.1.18