PACIFIC PSYCHIATRIC
INTERVENTION & WELLNESS CENTERS

HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

I. My Authorization

Print Name of Patient: _______________________ **Date of Birth:** ____________________

Person or organization providing information: **Person or organization requesting information:**

____ ____

The above party may disclose this health information to the following recipients:

Name (or title) and organization ____

Address ____

City ____________________ State _________ Zip __________

Phone ___________________ Fax ____________________ Email __________________

☐ - All of my health information ☐ - My health information related to the following: _______________________

☐ - My health information covering the period from ___________ (date) to __________ (date)

☐ - Other: ____

The purpose of this authorization is: ☐ - At my request ☐ - Other: ________________________

This authorization ends: ☐ - On (date)___________ ☐ - One year from date signed ☐ - Other ____________

II. My Rights

I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission. I may not be able to revoke this authorization if its purpose was to obtain insurance. In order to revoke this authorization, I must do so in writing and send it to the appropriate disclosing party. I understand that uses and disclosures already made based upon my original permission cannot be taken back. I understand that it is possible that information used or disclosed without my permission may be re-disclosed by the recipient and is no longer protected by the HIPAA Privacy Standards. I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create health information for a third party) and that I may have the right to refuse to sign this authorization. I will receive a copy of this authorization after I have signed it. A copy of this authorization is as valid as the original.

Signature of Patient: _________________________________ **Date**: ______________

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III. Additional Consent for Certain Conditions

This medical record may contain information about **physical or sexual abuse, alcoholism, drug abuse, sexually transmitted diseases, abortion, mental health treatment, or HIV testing and/or AIDS diagnosis or treatment**.

☐ - I consent to have the above information released. ☐ - I do not consent to have the above information released.

Signature of Patient or Authorized Representative: ____________________________ **Date**: ______________

If the patient is a minor or unable to sign, please complete the following:

☐ - Patient is a minor: ____ years of age. ☐ - Patient is unable to sign because: _________________________

Signature of Authorized Representative: ___________________________ **Date**: ______________

Print Name of Authorized Representative: _____________________________

Authority of representative to sign on behalf of the patient:

☐ - Parent ☐ - Legal Guardian ☐ - Court Order ☐ - Other: ______________________