HIPAA PRIVACY AUTHORIZATION

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)

Posted in our lobby is our *Notice of Privacy Practices.* It provides information about how our office may use and disclose your Protected Health Information (PHI):

- **You have the right** to review our *Notice of Privacy Practices* before signing this Patient Consent Form. Please take the time to do so at your convenience.

- **You have the right** to request that we restrict how your PHI is used or disclosed for treatment, billing, reimbursement, or medical office operations. Request for Restriction of PHI must be submitted to the Practice Manager (PM) in writing and signed by you as specified in our Notice. Our office does not have to agree with your Request for Restriction of PHI; however, if agreed, the office shall honor that request.

- **You have the right** to revoke this Patient Consent Form. *Revocation of Consent* must be submitted to the Practice Manager (PM) in writing and signed by you as specified in our Notice. A *Revocation of Consent* does not affect disclosures made prior to the date the *Revocation* was made.

  - Our *Notice of Privacy Practices* may change from time to time. If it does, you will receive a revised *Notice* on the first visit after changes to the *Notice* were made.
  - Our office may condition treatment upon execution of this *Patient Consent Form*.

- **Your signature below** signifies your consent to the use and disclosure of your PHI by our office during treatment, billing, reimbursement, and medical office operations as outlined in our *Notice*. You agree and consent that your PHI may be communicated to you via telephone or email (encrypted or unencrypted).

- **Extent of Authorization:**

  □ I authorize the release of my complete health record (including records related to mental healthcare and treatment of alcohol or drug dependency) **OR**

  □ I authorize the release of my complete health record with the exception of the following information:
  - □ Mental Health records
  - □ Alcohol/drug dependency treatment
  - □ Other (please specify) _____

- This authorization shall be in force and effect until _____ (date or event), at which time this authorization will expire.

This patient consent was signed by _____ _____
print name of patient or representative — representative

_____ _____ _____
patient signature — date — witness signature