

**HIPAA AUTHORIZATION**

**(VALID AUTHORIZATION UNDER 45 CODE OF FEDERAL REGULATIONS SECTION 164.508)**

**Statement of Intent:** It is my understanding that Congress passed a law called the Health Insurance Portability and Accountability Act ("HIPAA") and that this law limits disclosure of my protected medical information. I am signing this authorization because it is crucial that my medical providers readily give my protected medical information to my family and/or friends 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 Sec. 164.502(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 Sec. 164.508.

I, \_\_\_\_\_, an individual, hereby authorize

\_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_  
[insert name(s)]

**OR** 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, hospital, clinic, 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

\_\_\_\_\_  
[insert specific information]

**OR** 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 health care. Additionally, this disclosure shall include the ability to ask questions and discuss this protected medical information with the person or entity that 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 to

\_\_\_\_\_  
[Insert name of person(s) or group, such as "immediate family"]  
the "authorized persons."

**Termination:** This authorization shall terminate on the earlier of (1) the second anniversary of my death or (2) receipt of my written revocation by the covered entity. Proof of such receipt may be by certified mail, registered mail, facsimile confirmation or any other receipt evidencing actual receipt by the covered entity. Revocation shall be effective upon the actual receipt of the covered notice by the entity except to the extent that the covered entity has taken action in reliance on it.

**Re-disclosure:** By signing this HIPAA Authorization, I acknowledge that the information used or disclosed pursuant to it may be subject to re-disclosure by authorized persons and that, once disclosed, the information will no longer be protected by the rules governed by HIPAA. No covered entity shall require my authorized persons to indemnify the covered entity or to agree to perform any act in order for the covered entity to comply with this authorization.

**Instructions to my authorized persons:** My authorized persons shall have the right to bring a legal action in any applicable forum against any covered entity which refuses to recognize and accept this authorization for the purposes that I have expressed. In addition, my authorized persons are authorized to sign any documents which they deem appropriate to obtain the protected medical information.

**Valid document:** A copy or facsimile of this original authorization shall be accepted as though it were an original document.

**Waiver and release:** I hereby release any covered entity which acts in reliance on this authorization from any liability which may accrue from releasing my protected medical information and for any action taken by my authorized persons.

Signed this \_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_  
(month) (year)

Signature: \_\_\_\_\_

Date of birth: \_\_\_\_\_