HIPAA PRIVACY AUTHORIZATION FORM

Authorization for Use or Disclosure of Protected Health Information

1. I, _________________________, authorize my physician and/or his/her administrative staff to (check all that apply):

_____use the following protected health information, and/or

_____disclose the following protected health information to the following:

____

____

2. The protected health information to be used or disclosed is:

____

____

3. This protected health information is being used or disclosed for the following purposes:

____

____

4. This authorization shall be in force and effect until __________________ at which time this authorization to use or disclose this protected health information expires.

5. I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the practice's Privacy Content at Summit OB/GYN
I understand that a revocation is not effective to the extent that my physician has relied on the use or disclosure of the protected health information or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

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

7. My physician will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure except: 1) if my treatment is related to research, or, 2) health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.

Signature of Patient:____________________________Date:_______________________

Signature of Guardian___________________________Date:_______________________