Authorization Form under HIPAA*

This form should be used when release of a patient's protected health information is being made to anyone for a purpose other than treatment, payment or health care operations. The form should be adapted to meet the needs of a particular situation and a particular physician practice. Releases in which the form will be needed are discussed in the KMA HIPAA material regarding Authorizations. The information that is underlined should be filled in by the practice. Other information in brackets is designed to assist the patient in filling out the form.

I, ____________________, hereby authorize ______________________ to use and/or disclose my
Name of Patient /Representative Name of Physician/Practice
protected health information described below to ____.
Name of Person or Entity to receive the information

My protected health information will be used or disclosed upon request for the following purposes [please name and explain each purpose]: ____
____
____

This authorization for use and/or disclosure applies to the information described below [mark those that apply]:

- ❑ Any and all records in the possession of ____________________ including mental health, HIV,
  Name of Physician/Practice
  and/or substance abuse records. [Cross out any item you do not authorize to be released]
- ❑ Records regarding treatment for the following condition or injury:
  ____ on or about
  _________________________.
- ❑ Records covering the period of time ____________________ to ________________.
- ❑ Other [please specify - include dates]____.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to ____.
Name and Address of Contact Person at the Practice

I also understand that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my protected health information have acted in reliance upon this authorization.

I understand that I do not have to sign this authorization and that _________________________ may not
Name of Physician/Practice
condition treatment or payment on whether I sign this authorization.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by federal laws and regulations regarding the privacy of my protected health information.

This authorization expires on [please list a specific date or event] ____________________.

I certify that I have received a copy of this authorization.

____ ____________________
Signature of Patient or Personal Representative Date

____
Name of Patient or Personal Representative

____
Description of Personal Representative's Authority

Send Records To:
Rachel Johnson
Calloway County Schools
2110 College Farm Road
Murray, KY 42071

* The source of this document is the Kentucky Medical Association.