HIPAA Privacy Authorization Form

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)

1. Authorization

I authorize Prime Healthcare Center to use and disclose the protected health information described below _____ (individual seeking the information).

2. Extent of Authorization

I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV, or AIDS, and treatment of alcohol or drug abuse).

I authorize the release of my complete health record except for the following information:
- o   Mental health records
- o   Communicable diseases (including HIV and AIDS)
- o   Alcohol/drug abuse treatment
- o   Other (please specify

3. This medical information may be used by the person I authorize to receive the information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

4. This authorization shall be in force and effect until at which time this authorization expires.

5. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to consent a claim.

6. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

7. 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.

_____
Signature of patient or personal representative

_____
Printed name of patient or personal representative and his or her relationship to patient

_____
Date