HIPAA Privacy Authorization Form – Records Release Request

**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 Valley Pain Centers (healthcare provider) to use and disclose the protected health information described below to_____(individual seeking the information).

2. Effective Period
This authorization for release of information covers the period of healthcare from:

a. □_____to _____

OR

b. □ all past, present, and future periods.

3. Extent of Authorization

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

OR

b. □ I authorize the release of my complete health record with the exception of the following information:
   - □ Mental health records
   - □ Communicable diseases (including HIV and AIDS)
   - □ Alcohol/drug abuse treatment
   - □ Other (please specify)_____

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

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 the 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 or patient or personal representative

_____ _____
Printed name of patient or personal representative & his or her relationship to patient Date of Birth

_____
Date

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