

# HIPAA Privacy Authorization Form

**\*\*Authorization for Use and 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 \_\_\_\_\_ (your name), authorize \_\_\_\_\_  
(healthcare provider that has needed records) to use and disclose the protected health  
information described below to The Goldenberg GI Center and Dr. Goldenberg.

**\*\*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 or 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 purposes as I may direct.

5. This authorization shall be in force and effect until \_\_\_\_\_ (date you'd like access to  
end), at which time this authorization expires.

6. 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.

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

8. 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.

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Signature of patient or personal representative

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

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Date