PlushCare

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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 _____ **(healthcare provider/facility records are being obtained from)** to use and disclose the protected health information described below to _____
(individual seeking the information/facility that will be receiving the records).

Doctor/Clinic to Release Records to_____
Office Address_____
Office Phone_____
Office Fax_____

Release to self ☐

2. Effective Period

This authorization for release of information covers the period of healthcare from **(must select A or B)**:

a. ☐ _____ to _____ (enter to and from dates).

OR

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

3. Extent of Authorization

(must select A or B)

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 **(those check marked will not be released):**

- ☐ Mental health records
- ☐ Communicable diseases (including HIV and AIDS)
- ☐ Alcohol/drug abuse treatment
- ☐ Other (please specify):_____

4. Type of Record Request

(must select A, B or C)

a. ☐ Medical Appointment Records Only

****OR****

b. ☐ Therapy Appointment Records Only

****OR****

c. ☐ Both Medical and Therapy Appointment Records

****OR****

d. ☐ Other (please explain)_____

5. 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.

6. This authorization shall be in force and effect until as selected below at which time this authorization expires. (must select A or B):

a. ☐ _____**(enter a date of expiration).**

****OR****

b. ☐ Indefinitely

7. 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 contest a claim.

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

9. 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 (sign below)

_____

Printed name of patient or personal representative and his or her relationship to Patient (print name) ;_____

DOB of Patient _____

Date signed _____