movementbodywork
form, strength, movement, foundation, structure

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HIPPA 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 Samuel Hobbs LMT to use and disclose the protected health information described below to:

_____
(individual/entity seeking the information)

2. Effective Period

This authorization for release of information covers the period of health care from:

☐ From: _____ To: _____

☐ All Past, Present, and Future periods

3. Extent of Authorization

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: _____

4. Method of Records Transfer

I authorize the transfer of my protected health information via:

☐ Personal Email

☐ Secure Web Portal (client must provide access and means for transfer)

☐ US Postal (client understands they are responsibile for any fees/costs associated with print and postage of their records)

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 _____, at which time this authorization form expires.

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. _____

Printed Name: _____
Client Name (or Personal Representative)

Relationship: _____
Relationship to Client if Representative

Signature: _____ **Date:** _____
Client Signature (or Personal Representative)