Standard Authorization Form

Fields marked with an asterisk (*) are required to be completed. Failure to provide additional identifying information is Section I may result in the ability to respond to this request. This form is not a patient access request under 45 CFR 164.524. Records released pursuant to this authorization may include information concerning testing, diagnosis or treatment of HIV/AIDS, psychiatric and/or drug/alcohol treatment, and/or sexual assault.

FORM A AUTHORIZATION FOR RELEASE OF INFORMATION FROM COVERED ENTITIES (OTHER THAN PART 2 PROGRAMS)

SECTION I

First Name: _____ M.I: _____

Last Name: _____ Date of Birth *: _____ dd / mm / yyyy

Social Security Number: _____ Address: _____

City: _____ State: _____

Zip Code: _____

I hereby authorize the disclosure of health information about the above individual as follows.

SECTION II

Disclosing Entity (Covered Entity such as a health plan/insurer or provider) *:

Address: _____ Telephone Number: _____

City: _____ State: _____

Zip Code: _____ Recipient (Person or Entity) *: _____

Contact Information (E.g. telephone number, email address, fax number, street address, etc):

SECTION III

Reason for Disclosure *

Health information to be disclosed: *

Specify time period, if desired: Release only information from the period (mm/dd/yyyy) to: dd / mm / yyyy

(mm/dd/yyyy): _____ dd / mm / yyyy

SECTION IV

This authorization will remain in effect revoked or shall expire on date or event specified below. I understand that I may revoke or cancel this authorization at any time by submitting written revocation in the manner specified by disclosing entity, except to the extent that action has been taken in reliance on this authorization. If this authorization has not been revoked, it will expire on the date or completion of the event stated below. If no date or event is specified below, this authorization will expire in one year.

Expiration Date or Event (mm/dd/yyyy): _____ dd / mm / yyyy

I understand that I may not be denied treatment, payment, and enrollment in the health plan, or eligibility for benefits for refusing to authorize disclosure unless such denial is permitted under state and federal law. I understand that information disclosed by this authorization, except as prohibited by 42 CFR Part 2 or other applicable law, may be subject to re-disclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule [45 CFR Part 164].

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Date (mm/dd/yyyy) *: _____ dd / mm / yyyy **Date (mm/dd/yyyy):** _____ dd / mm / yyyy

Relationship of Personal Representative to Individual

- ◯ Parent
- ◯ Legal Guardian
- ◯ Healthcare Power of Attorney
- ◯ Executor/Administrator
- ◯ Other
- ◯ N/A

Method of Delivery (E.g. paper, fax, electronic):

Date Released: _____ dd / mm / yyyy