Austin Springs Women's Health

HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Date: _____ ID:_____
(office use)

I. **THE PATIENT**. This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

Patient's Name:
_____

Date of Birth:
_____

II. **AUTHORIZATION**. I authorize **AUSTIN SPRINGS WOMEN'S HEALTH** ("Authorized Party") to use or disclose the following: (check one)

☐ - All of my medical-related information.
☐ - My medical information ONLY related to:
_____
☐ - My medical-related information from _____ to
_____
☐ - All billing inquiries, itemized statement & explanation of coverage to include but not limited to: diagnosis and procedure/visit(s) performed.
☐ Other:
_____

Hereinafter known as the "Medical Records."

III. **DISCLOSURE**. The Authorized Party has my authorization to disclose Medical Records to: (check one)

☐ - Any party that is approved by the Authorized Party.

☐ - ONLY the following party:
Name:
_____
Relationship:
_____
Phone:
_____

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IV. PURPOSE. The reason for this authorization is: (check one)

☐ - **General Purpose**. At my request (general).

☐ - **Billing**. To allow the Authorized Party to communicate with me for marketing purposes when they receive payment from a third party.

☐ - **Appointment/Visits/Lab Results:**
_____

☐ - **Other**:
_____

V. TERMINATION. This authorization will terminate: (check one)

☐ - Upon sending a written revocation to the Authorization Party.
☐ - On the following date: _____
☐ - Other: _____

VI. ACKNOWLEDGMENT OF RIGHTS.

I understand that I have the right to revoke this authorization, in writing and at any time, except where uses or disclosures have already been made based upon my original permission. I might not be able to revoke this authorization if its purpose was to obtain insurance.

I understand that uses and disclosures already made based upon my original permission cannot be taken back.

I understand that it is possible that Medical Records and information used or disclosed with my permission may be re-disclosed by a recipient and no longer protected by the HIPAA Privacy Standards.

I understand that treatment by any party may not be conditioned upon my signing of this authorization and that I may have the right to refuse to sign this authorization.

Signature of Patient: _____ Date: _____

Print Name: _____