HIPAA Release of Information 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) \*\*

**Authorization:**

I authorize Triumph Center/Laura Mullis to use and disclose the health information listed

below to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

**Effective Period:**

This authorization for release of information covers the period of healthcare  from:

1. □ \_\_\_\_\_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*\*OR\*\*

b. □ all past, present, and future periods. \*\*3. Extent of Authorization\*\*

**Limits of Release:**

a. □ I authorize the release of my complete health record (including all assessment, treatment notes and clinical diagnosis).

b. □ I authorize the release of verbal information of my progress in treatment.

\*\*OR\*\*

b. □ I authorize the release of my complete health record/progress in treatment  with the exception  of the following information:

□ Mental health records

□ Communicable diseases (including HIV and AIDS)    □ Alcohol/drug abuse treatment

□ Other (please specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Guidelines of Release**

* This medical information may be used by the person I authorize to receive  this information for medical treatment or consultation, billing or claims payment, orother purposes as I may direct.
* This authorization shall be in force and effect until \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (date  or event), at which time this authorization expires.
* 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.
* I understand that my treatment, payment, enrollment, or eligibility for  benefits will not be conditioned on whether I sign this authorization.
* 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 Person Authorizing Release Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name of Person Authorizing Release Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness Date