

HIPAA Privacy Authorization Form – From AFS
AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

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)

I _____ DOB _____ authorize Associated Foot Surgeons of Southwest IL to release my protected health information described below to:

Person/Facility authorized to receive this information:

Address _____

Phone Number _____ Fax Number _____

Specific information to be released/disclosed from _____ to _____ specified below:

- () Complete Medical Records OR () Specify one or more of the following:
- () Operative Reports
- () Clinic Notes
- () Laboratory
- () XRays (Disks are \$20, due upon receipt)
- () Billing and Claim Records
- () Other (Specify) _____

This authorization expires on _____.

____ I authorize the release of my complete health record with the exception of:
____ Mental health records ____ Communicable diseases
____ HIV or AIDS ____ Alcohol/drug abuse treatment
____ Other (Specify): _____

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.

Print Full Name

Date

Signature of Patient, Parent or Legal Guardian