Meetinghouse Family Physicians
(856) 596-9050

HIPAA 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. I authorize **Meetinghouse Family Physicians** to use and disclose the protected health information described below to

   Name ____________________________ Relationship______________________

   Name____________________________Relationship______________________

2. Authorization for release of PHI covering the period of health care (check one)
   - ❏ From (date)____________ to (date)____________ or
   - ❏ All past , present and future periods

3. I hereby authorize the release of PHI as follows (check one)
   - ❏ My complete health record (including records relating to mental health care, communicable diseases, HIV or AIDS, and treatment of alcohol/drug abuse) .OR
   - ❏ My complete health record *with the exception of the following* (check as appropriate)
   - ❏ Mental health records
   - ❏ Communicable diseases (including HIV and AIDS)
   - ❏ Alcohol / drug abuse treatment
   - ❏ Other (please specify):_______________________________________

4. 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.

5. This authorization shall be in force and effect until__________(date or event), at which time this authorization expires or nine (9) months after my death.

6. 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 the claim.

7. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

8. 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 patient or personal representative_______________________________Date__________

Printed name of patient or personal representative______________________________Date__________