HIPAA Privacy Authorization Form

Beacon Pain Clinic
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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. Authorization
I authorize_____(healthcare provider) to use and disclose the protected health information described below to Beacon Pain Clinic (individual seeking the information).
2. Effective Period
This authorization for release of information covers the period of healthcare from: _____ to _____. If not specified release is effective for 1 year from signature date.
3. Extent of Authorization

- a. I authorize the release of my complete health records (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).

OR

- b. I authorize the release of my complete health record with the exception of the following information:
  - 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. 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.
6. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.
7. 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 and his or her relationship to patient)

_____ DOB:_____