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HIPAA Privacy Authorization Form (45 CFR 164.510 b)

I, _____, give permission to all my health care and medical service provider and payers to disclose and release my protected health information described below to:

Name(s)	Relationship
_____	_____
_____	_____
_____	_____

Health Information to be disclosed:

- ○ My complete health record (including but not limited to diagnoses, lab tests, pathology, prognosis, treatment, and billing, for all conditions)

This health information may be used to enable the people I authorize to know and understand my condition and my treatment or treatment options, for treatment or consultation, for claims payment purposes, or related reasons.

This authorization shall be effective until (Check one):

- ○ All past, present, and future periods OR
- ○ Date or event: _____
  unless I revoke it. (NOTE: You may revoke this authorization in writing at any time by notifying your health care providers, preferably in writing.)

_____
Name of the Individual Giving this Authorization

_____ _____
Signature of the Individual Giving Authorization Date