If you would like some person other than yourself to have access to your medical records and information, and allow health care providers to release such information to that person, you must authorize the release of the information in writing.

- In **Section 1** you need to insert the name of the health care provider (hospital, physician, etc.) who is authorized to release the information, and the name of the person who is authorized to receive the information.
- In **Section 2** you first need to indicate what **time period** is covered by the authorization, and then what **type** of information is allowed to be released.
- In **Section 4** you need to indicate **how long** the authorization is to remain effective, for example until a certain date or until your death. You retain the power to **revoke** the authorization at any earlier time.
- The form needs to be **signed** by the patient or by the personal representative of the patient, such as a parent if the patient is a minor.

HIPAA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information
(Required by the Health Insurance Portability and Accountability Act – 45 CFR Parts 160 and 164)

1. I, _____, hereby authorize
[Printed Name of Patient]

Downtown Vision Centre & Camas Vision Centre to use and/or disclose the protected health information described below to:

_____	_____
[Name of Authorized Persons]	**[Relationship]**
_____	_____
[Name of Authorized Persons]	**[Relationship]**
_____	_____
[Name of Authorized Persons]	**[Relationship]**
_____	_____
[Name of Authorized Persons]	**[Relationship]**

TURN OVER ⇨

2. Authorization for Release of Information. Covering the period of health care from

a. ☐ _____ to _____

OR

b. ☐ all past, present and future periods:

AND

a. ☐ I hereby **authorize the release of my complete health record** (including records relating to mental health care, communicable diseases, HIV or AIDS, and treatment of alcohol/drug abuse).

OR

b. ☐ I hereby **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): _____

3. 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.

4. This authorization shall be in force and effect until _____, at which time this authorization expires. **[Date or Event** ie. 12/31/2029, Death, Revoked**]**

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.

X_____ _____ / _____ / _____

[Signature of Patient or Personal Representative**]** **[Date]**

X_____ _____

[Printed Name of Personal Representative if applicable] [Relationship]