HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

Print Name of Patient: _____

Date of Birth: _____ SSN: _____

I authorize the following using or disclosing party:

Name (or title) and organization _____

Address _____

City _____ State _____ Zip _____

Phone _____ Fax _____ Email _____

to use or disclose the following health information.

☐ - All of my health information ☐ - My health information relating to the following treatment or condition: _____

☐ - My health information from _____ (date) to _____ (date) ☐ - Other: _____

The above party may disclose this health information to the following recipient:

Name of organization: North Central Indiana Medical Clinic

Address: PO Box 247

City: Milford State: IN Zip:46542

Phone:574-832-6246 Fax:574-832-2001 Website: ncimedical.com

The purpose of this authorization is (check all that apply):

☐ - At my request

☐ - Other: _____

This authorization ends: On (date)_____

I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission. I may not be able to revoke this authorization if its purpose was to obtain insurance. In order to revoke this authorization, I must do so in writing and send it to the appropriate disclosing party.

I understand that uses and disclosures already made based upon my original permission cannot be taken back.

I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and is no longer protected by the HIPAA Privacy Standards.

I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create health information for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization.

This medical record may contain information about physical or sexual abuse, alcoholism, drug abuse, sexually transmitted diseases, abortion, or mental health treatment

This medical record may contain information concerning HIV testing and/or AIDS diagnosis or treatment.

<u>If the patient is a minor or unable to sign, please complete the following</u>:

☐ - Patient is a minor: _____ years of age

☐ - Patient is unable to sign because: _____

Print Name of Authorized Representative: _____

Authority of representative to sign on behalf of the patient:

☐ - Parent ☐ - Legal Guardian ☐ - Court Order ☐ - Other: _____

Signature of Patient or Authorized Representative: _____ Date: _____