

# HIPAA Authorization Form

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## AUTHORIZATION FOR RELEASE OF INFORMATION

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### **Section A: Must be completed for all authorizations**

I hereby authorize the use of disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

**Patient name:** \_\_\_\_\_ **ID Number:** \_\_\_\_\_

**Persons/organizations providing the information:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
**Person/organizations receiving the information:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Specific description of information (including date(s)):** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### **Section B: Must be completed only if a health plan or a health care provider has requested the authorization**

- The health plan or health care provider must complete the following:
  - What is the purpose of the use or disclosure? \_\_\_\_\_
  - Will the health plan or health care provider requesting the authorization receive financial or in-kind compensation in exchange for using or disclosing the health information described above?  
Yes \_\_\_\_ No \_\_\_\_
- The patient or the patient's representative must read and initial the following statements:
  - I understand that my health care and the payment for my health care will not be affected if I do not sign this form. Initials: \_\_\_\_\_
  - I understand that I may see and copy the information described on this form if I ask for it, and that I get a copy of this form after I sign it. Initials: \_\_\_\_\_

### **Section C: Must be completed for all authorizations**

The patient or the patient's representative must read and initial the following statements:

- I understand that this authorization will expire on \_\_\_/\_\_\_/\_\_\_ (DD/MM/YYYY) Initials: \_\_\_\_\_
- I understand that I may revoke this authorization at any time by notifying the practice in writing, but if I do it won't have any affect on any actions they took before they received the revocation. Initials: \_\_\_\_\_

\_\_\_\_\_  
**Signature of patient or patient's representative** **Date**  
(Form *MUST* be completed before signing)

**Printed name of patient's representative:** \_\_\_\_\_  
**Relationship to the patient:** \_\_\_\_\_

### **\*YOU MAY REFUSE TO SIGN THIS AUTHORIZATION\***

I understand that I may revoke this authorization, in writing, at any time by sending a written notification to the following: Medical Record Department, 8230 Walnut Hill Lane Suite 514, Dallas, Texas 75231